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Personality: an approach to the study of perception

By H. PHILLIPSON and JULIET HOPKINS*

I. Introduction

In many experiments designed to explore the influence of personality factors on perception efforts are made to discount individual differences in the perceptual process, to assign them to random error (see Bruner, 1951), or to explain them only in terms of consciously stated interests and experience. Although considerable evidence has been obtained to show that the extended as well as the immediate situation in which an experiment is done, including the interpersonal relations involved, may have marked influence on the subject's responses, the explicit 'set', as part of the experimental design, is usually given weight at the expense of any idiosyncratic reactions the subject may show in the situation.

Furthermore, it is likely that in many experiments unconscious determinants are either given little scope in the task or stimulus used, or they are masked because the subject is not clear what he is expected to do or why he is to do it. Only where it is possible to emphasize the effect of unconscious influences, and to keep under control situational factors that affect their strength and direction, will the evidence be sufficiently clear and distinctive to permit examination of the interplay of conscious and unconscious influences within the perceptual process (Klein, Spence, Holt & Gourevitch, 1958).

We shall attempt to emphasize unconscious influences on the perceptual process by manipulating the main variables appropriate to this aim, as a background to our attempt to demonstrate that it is possible, under these conditions, to identify the operative personality systems from samples of the perceptual

process. Our approach will invite and take account of the idiosyncratic responses of individual subjects.

If it is possible to design an experimental procedure in a clinical setting, which, as it were, puts under the microscope samples of the perceptual process, so that evidence of the subject's ways of reconciling his conscious and unconscious awareness of the situation is more clearly portrayed, then it may be possible to sharpen some of the questions, and expose some of the dilemmas that restrict our understanding of personality. A clinical setting offers opportunities to control, or at least keep under attention, some of the more important situational and interpersonal variables that may influence perception. We know that the stimulus situation used is made up of the extended situation in which the test is done (Bruner & Tagiuri, 1954), the immediate test situation including the apparatus used, and the procedure the subject has to take part in, in addition to the main stimulus presented, e.g. a picture. All these aspects of the total stimulus situation have underlying as well as explicit meaning for the subject: in particular they have interpersonal implications at unconscious as well as at conscious levels. Whether these many aspects of the total situation have concordant or differing implications for the subject will affect his responses.

The clinical situation also provides an opportunity for independent investigation of personality at a degree of intimacy and depth that makes a comparison of the results of such an investigation with perceptual data meaningful. It is true that the clinical approach relies considerably on the skill of the clinician, and many of the procedures and test situations used are frustratingly complex as judged by the standards of the experimental psychologist.

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Even so, the reconciliation of the requirements of experimental method and those of clinical practice is an objective that has considerable advantages on both sides.

II. THE METHOD AND ITS RATIONALE

(i) *The main stimulus presented*

Our basic assumptions are derived largely from the object relations theory of psychoanalysis (Klein, 1948, 1960; Fairbairn, 1952; Guntrip, 1961), from which it is postulated that the primary stimulus values in any situation centre around the human relationship issues in it. The extent to which unconscious perceptions and behaviour are dominant in a situation depends on the degree of fit between the internal 'world' of object relations experience, in terms of unconscious wishes and expectancies, related anxieties and defences, and the external 'world' in which human relationship issues are encountered (Phillipson, 1955, 1962; Carr, 1960). If the intention then is to emphasize unconscious determinants in the perceptual process, in a way that makes them readily identifiable in these terms, it is necessary to use stimulus situations in which human relationships are the main content. The set of 12 pictures used in the Object Relations Technique is made up of three series in which the nuclear human relationship situations, one person, two persons, three persons and group, are presented in three different contexts wherein the environmental setting and emotional climate of the situation are varied. In the 'A' series there is little or no physical setting: the figures and surroundings are in light grey shading. In the 'B' series, where the figures and setting are portrayed in sharp outline in contrasting black shading and white, a number of objects of the physical world are clearly introduced. In the 'C' series the figures and setting are portrayed in considerable detail but in light definition upon which colour elements have been introduced. A brief description of the 12 pictures is given in an appendix.

(ii) *The clinical setting*

The ten patients who took part in the experimental procedure each had a psychiatric interview as their first contact with the outpatient clinic, immediately before their interview with the psychologist during which the tachistoscopic presentation of O.R.T. pictures was made. The approach used in the psychiatric interview will influence the reliability of the patient's perceptual responses in his subsequent interview with the psychologist to the extent that the explicit and implicit meaning, for the patient, of the two experiences coincide. The form of psychiatric interview used in this instance sets out to orientate the patient to an examination of his presenting difficulties in terms of his interpersonal relationships, and seeks to demonstrate this approach as meaningful in providing understanding and help for his problems.

(iii) *The test situation*

(a) *The motivations in the situation and the interpersonal implications*

In all cases the same psychologist interviewed the patient after psychiatric interview. Psychiatrist and psychologist were both male. By these means an attempt was made to keep constant the interpersonal dynamics inherent in the three-person situation (patient, psychologist, psychiatrist). It was easy, on the basis of the psychiatric interview described above, to introduce the need to understand more fully how the patient 'looks at things' in his life, as a meaningful approach to future help with his problems. In this way the patient's motivation to do the task is strengthened and cross-purposes between the intention of the psychologist and psychiatrist in respect of his problems are diminished.

(b) *The tachistoscope*

The instrument was made from an old, quite silent, 35 mm. slide projector fitted with a Compur shutter which permitted exposure of $\frac{1}{5}$ to $\frac{1}{100}$ sec. The O.R.T. pictures, reproduced as colour slides, were projected on to a white screen, placed with its back to the window, and

about 5 ft. away from the patient who was seated just to the side of the projector. The image presented was the same size as the O.R.T. pictures used in standard presentation. In these conditions a clear image could be exposed in a normally lighted room. This approximation to normal clinical conditions was designed to minimize the intrusion of individual unconscious phantasies which might arise from being confronted with a strange procedure in unusual circumstances (i.e. a darkened room).

(c) *The procedure*

Reference was made to the psychiatric interview and the need to understand the patient's difficulties more fully. He was told that he would be asked to look at some pictures presented to him for a very brief time through the slide projector. It was suggested that the way he 'looked at' things might help us understand how he felt about some of the questions for which he was seeking help. In order that the psychologist might have some background against which to understand the way he looked at things in his life, the patient was invited to discuss his work and interests with special reference to the things he found most enjoyable and satisfying, and on the other hand those aspects that were difficult or frustrating (see Phillipson, 1962). This non-directive discussion of not more than 10 minutes allows the patient to satisfy himself about the intentions of the psychologist, i.e. to confirm that what is being done is relevant to the patient's present needs.

The subject was told that he would see each picture a number of times until he felt he could see no more in it. He was asked to say what he saw, all that he saw, each time an exposure was made. The pictures were presented in the standard order (see Appendix). An exposure time of $\frac{1}{10}$ sec. was used. The responses were tape recorded in an adjacent room.

III. THE SUBJECTS

The subjects were ten applicants (five men and five women) to an outpatient psychiatric clinic. No attempt was made to select particular patients; they were taken in the order in which they happened to be passing through the ordinary clinic intake procedure.

The subjects ranged from 19 to 36 years with an average of 25·6 years. They were all of above average intelligence.

For purposes of identification in the research and in the discussion that follows, they are designated A, B, C, D, E (the five female subjects) and V, W, X, Y, Z (the five male subjects).

The psychiatric interviews revealed that all subjects except two (B and E) were holding jobs or working as students; they were leading comparatively normal lives and continued to do so in the period immediately following their diagnostic assessment. Subject B entered a mental hospital soon after her referral to our Clinic, while subject E left her husband and returned home to be cared for by her mother.

The subjects sought help for such problems as depression, tension, anxiety, sleeplessness, social inadequacy, minor conversion symptoms (e.g. tingling of face and hands), inability to make lasting relationships with the opposite sex and some specific sexual problems, such as premature ejaculation. Two subjects (Y and Z) also suffered from feelings of unreality and uncertain identity.

IV. RESULTS

A. *Variety and nature of the data from the perceptual experiment*

Subjects were normally satisfied by 4 to 6 exposures of each card. Occasionally a subject required only 2 or 3 exposures of a card, or, very rarely, as many as 7 or 8.

The average number of exposures for A series was 5·2, for B series 5·0 and for C series 6·1.

These figures compare with 5·5 (B series) and 5·8 (C series) obtained in a recent study by Vernon (1961). The greater average number of exposures (6·1) required for the C series was in accordance with our expectations since these cards are very vague and also contain colour

and many indistinct indications of detail. All subjects described the C series of cards less accurately than either the A or B series. The amount of material given varied greatly from subject to subject. Some subjects did not hesitate to make guesses and speculate, others withheld judgement until they were fairly certain of what they had seen. The variation in the amount of spontaneous inference made by different subjects seems very similar to that shown by Vernon's subjects (Vernon, 1961).

The following are two examples of responses to card A 1 (the first card in the series), showing contrasting amounts of inference.

Subject E (*female*)

1. A figure. I think it was a man.
2. Some bushes round him. On both sides.
3. There's a tree on the right side.
4. Nothing more.
5. No.

Subject Y (*male*)

1. I just saw a couple of silhouettes, I was hardly prepared for the suddenness of it.

2. Ah—I can see a silhouette—a man—a silhouette of a man stepping forward from what may be a mist—a mist of people, maybe a fire, maybe a burning building. A man stepping forward out of dimness, perhaps a man coming out of the past.

3. On the lower left the part of a silhouette of another being. I wasn't sure whether it was reclining or not.

4. I can't really add anything to that.

5. Well, I saw other creatures there too, other figures and shapes, silhouettes. I don't know really what else I can see, I saw some other figures there, yes.

6. Yes, there were two other figures and sort of charcoal shading down the left-hand side which gives this misty appearance. In fact it very well could be Christ on the Cross I suppose, except that I didn't see his arms—we had the shading on the left but the central figure could be a symbol of Christ crucified.

Subject Y was unusually free in his expression of inference and fantasy. In general the records tended to fall between these two contrasting examples with regard to the amount of inference. It is perhaps of interest that although the subjects were all motivated by the desire for psychiatric help and might therefore have been expected to make inferences and reveal fantasy more freely than subjects who had nothing to gain from such personal revelation, there were three subjects in the sample who restricted themselves to the tersest descriptions of what they saw, and only two subjects who consistently gave responses as rich in inference as the second example quoted above. In general, the subjects made considerable effort to come to terms with the objective features of the material, and inference tended to be incidental. These findings are similar to those reported by Vernon.

Vernon classified responses to this perceptual task into three categories—form and lighting, identification of objects and persons, and inferences. She found that responses did not necessarily follow each other in this succession, and our results are in agreement with this finding. However, there was a slight tendency for subjects to comment first on form and lighting, before proceeding to more specific or inferential responses.

B. *Method of analysis of perceptual data*

Our aim was to derive comparable personality assessments from the perceptual data and from the impressions formed in the psychiatric interview. In order to do this, a scheme of headings covering the main areas of personality dynamics was drawn up. The headings chosen were based on a psychoanalytic rationale and were those often used at the clinic when analysing projective material.

The headings used are those italicized in the examples (given on pages 9 and 11) of the personality assessments made by psychologist and psychiatrist from their respective data.

The tachistoscopic presentations were given by psychologist L, the personality assessments from this data were made by psychologist M. Three psychologists, N, O and P, took part in

the matching of these assessments with those of the psychiatrist.

How, then, did psychologist M analyse and assess the perceptual data in terms of these headings? It is very difficult in a brief paper to give a full explanation of our method, but we will attempt to illustrate our procedure with the material from one of our subjects. We have selected a male subject, W, for illustrative purposes since he was one of the subjects who restricted himself fairly closely to a description of the perceptual material and had little recourse to inference. We have chosen his record in order to illustrate that our method of analysis is not dependent upon the presence of idiosyncratic inference in the records, though where this does occur it is obviously helpful in revealing unconscious dynamics. Our method of analysis is based primarily upon the subject's perception of the card, his omissions and distortions, his selective over- and under-emphasis.

When interpreting responses to Rorschach ink blots, O.R.T. cards or other projective material, the psychologist normally relies heavily on normative data and his own experience as a yard-stick by which to judge unusual perceptions and elaborations. Unfortunately we have no reliable norms for the perception of O.R.T. cards under tachistoscopic conditions. However, our sample of ten subjects was augmented by nine further subjects (also psychiatric out-patients) whose responses to the tachistoscopic exposure of the cards had been obtained previously in a trial series. The responses of the nineteen subjects to this perceptual task provided tentative norms that were used as a rough guide to the more popular perceptions of the cards: they indicated what it was possible to see under tachistoscopic conditions, and hence what were significant omissions or distortions.

C. *An illustrative example of the analysis of the perceptual data* (*subject* W)

Psychologist M made comments on the subject's responses to each card in turn, in her attempt to decide what unconscious object-

relationship the subject was trying to establish, what anxieties this aroused in him, what defences he utilized to deal with these anxieties, and, lastly, with whom he was identified.

We will present for illustration the responses of subject W to the first four cards of the series.

Card A 1

1. A man.
2. The same picture—a silhouette of a figure. I imagine it was a man.
3. Yes, there is a figure there, but there is something at the bottom, something else.
4. No, I don't know what there is, whatever it is, it dominates.
5. The same.
6. The same.

Here are the psychologist M's comments on his perception:

1 *and* 2

He grasps the main feature of the picture but is rather cautious about committing himself to what he has seen; he cannot see the figure definitely as a man, although this inference is usually made readily.

3 *and* 4

He continues to be cautious as he attempts to structure the shading at the bottom of the card. This shading provides the potentiality for developing a relationship with, or at least providing a secure setting for, the central figure, but it seems that he cannot anticipate real security in the development of a two-person relationship for he fears that the 'something at the bottom' would dominate and not prove helpful or supportive. His assertion that the shading dominates is in contradiction to the practically universal interpretation that the central figure dominates this card. It seems then that this subject has a particularly strong fear of being dominated in a two-person relationship; at one level of mental functioning this must indicate a fear of loss of control and of being overwhelmed by unconscious feelings, while at a more nearly conscious level it may be experienced, by means of projection, as a fear of

being dominated by someone else. In response to his anxieties he represses the development of fantasy and evades the further development of the relationship.

In summary—he makes a tentative approach towards the establishment of a two-person relationship but he is afraid of being dominated by his own unconscious feelings, i.e. he is afraid of loss of control. He defends himself by repressing feelings and fantasy and projecting his unconscious feelings on to the object; he then fears domination by the object and defends himself further by adopting a detached, inert attitude towards it and failing to develop the relationship. In everyday life he is probably identified with a silhouette, a façade, whose emotions are so repressed that he feels hollow.

Subject W's responses to the second card were as follows:

Card A2

1. Two people.
2. Two people.
3. I think a man on the left and a woman on the right wearing a hat.
4. Yes.
5. Probably the woman is touching her arm round his chest or something.
6. I am not sure about this, but there is a man and a woman anyway, I would think.

The psychologist made the following comments:

1–4

Caution and reticence gradually break down to give freedom of expression to a heterosexual relationship. The percept of the woman wearing a hat is highly unusual but does not represent a gross distortion of the picture. It implies that the woman is dressed and may therefore function as a protection against the anxieties inherent in a more intimate sexual relationship. However, the mention of any other article of clothing would also have served this function and the significance of the hat may lie in its importance as a prominent appendage—the hat probably represents a penis. If this is so the subject must have a prevalent unconscious fantasy that in a sexual relationship the woman possesses or acquires a penis. This would be associated with fear of castration by women and might reveal itself clinically in partial or complete impotence.

It seems that the fear of being dominated in a two-person relationship, indicated by his response to card A 1, has here crystallized as a fear of being dominated by a castrating woman.

5

The dominance of the woman is confirmed. She makes the sexual advance and the man adopts a passive role. It is fairly common for the two figures to be perceived as touching each other, but the inference that it is the woman touching the man is very unusual. Moreover, when the figures are perceived as touching each other they are usually seen to be holding hands; the subject's perception of the woman touching the man's chest is not really congruent with the picture—if she were seen reaching out to him it would be more accurate to see her touching him at a lower bodily region. This suggests that the chest is used as a defensive displacement from the genital area on account of castration anxiety. However, the use of the word 'touching' implies a positive contact and hence positive features in the relationship, which must help to counteract the acute castration anxiety.

6

More nearly conscious uncertainty about the nature of heterosexual relationships break through.

In general, the directness with which the heterosexual relationship is stated in response to this card is unusual in the tachistoscopic series and suggests that this man must be actively concerned with establishing sexual relationships in real life. However, he can only adopt a passive, semi-potent attitude towards women.

In summary—he is concerned with a two-person sexual relationship in which the dominant anxiety is that of castration by the

woman. He defends himself by retreating to a passive role and adopting a semi-potent or impotent position.

Card C3

1. Nothing.
2. Someone sitting down.
3. Someone sitting down and someone standing over him.
4. A man leaning on a mantelpiece over a fireplace, someone sitting there.
5. —
6. There is a red mark somewhere.
7. Yes, there is a mark, a red mark, it is distinctly a red mark.
8. That's all I am seeing.

The psychologist wrote:

1–4

This is an outstandingly good perception of this card under tachistoscopic conditions, and means he is capable of accurate reality testing. The implication that a man is 'standing over' another man indicates that in relationships with men he may adopt a dominant or a passive attitude rather than relate himself as an equal.

6 *and* 7

The accurate description of the vivid red (mentioned in only 9 of the 19 records) suggests that he is able to accept intellectually the existence of passionate feeling but he cannot integrate it into his description of the card or into his relationships. Instead he defers dealing with it until he has mastered the objective features of the human relationship presented to him; he then isolates it and keeps it at a safe distance.

In summary—the subject is concerned in making a two-person relationship with a man. This appears to arouse anxiety in him about rivalry and the control of passionate feeling. He defends himself against these anxieties by structuring the relationship with the other man in terms of dominant and submissive roles and by the use of isolation and the repression of affect.

Card B3

1. Didn't see anything at all.
2. Two figures in the door.
3. That's exactly what I see again, two figures in a door. Somebody inside.
4. The person inside is coming to meet the two in the doorway.

The psychologist wrote:

The subject required only four exposures of this card, fewer than any other card. Since he did not pause to differentiate the sexes of the figures or attempt to master any detail, it suggests that this card was particularly anxiety-arousing for him: it must have touched too directly on his most prominent problems.

2–4

Again his reality testing is good and he correctly perceives the essential features of the three-person relationship presented to him. However, he entirely evades the emotional implications of the relationship. In contrast to his approach to the three preceding cards he makes no attempt to differentiate the sexes of the figures. Even under tachistoscopic conditions the two figures in the doorway are commonly seen as a heterosexual couple, but it seems that in a three-person relationship he cannot even allow a simple statement of sex, let alone permit the proximity or intimacy of these two figures. Instead he denies the existence of the couple's sexuality and of the isolation, jealousy and curiosity of the third figure—he attempts to combine them all in an unspecified, apparently friendly relationship. Both the painful and satisfying aspects of the triangular relationships are repressed, leading one to conjecture that oedipal situations are a source of major difficulty for him.

In summary—the subject is concerned with oedipal relationships but his fear of his jealousy and of being left out is so great that he denies parental sexuality, intrudes on the parental relationship and represses all painful and rivalrous affects. This results in pleasant superficial relationships.

Space forbids the presentation of the subject's responses to the remaining eight cards and their analysis, but a summary of the analysis of the entire record is presented in Table 1.

When the tabular expression of the analysis of the 12 cards had been completed, psychologist M assessed each record as a whole, selecting its dominant features for inclusion in the final assessment of personality.

As a further illustration we give the final personality assessment of subject W on page 9.

Table 1. *Subject W (male). Summary of the analysis of the perceptual material*

Card	Dominant object relationship	Anxiety	Defence	Identification
A1	Two-person	Loss of control of unconscious feelings in the context of developing a two-person relationship, more nearly consciously experienced as fear of being dominated in such a relationship	Repression	A detached man with a hollow façade threatened with domination by his unconscious feelings
A2	Two-person heterosexual	Castration by woman	Passivity and withdrawal to a semi-potent position	Passive man submitting to dominant woman
C3	Two-person with male	Rivalry. Passionate feeling	Structuring of relationship into dominant and submissive roles. Isolation and repression of affect	Passive or dominating man
B3	Three-person oedipal	Rejection, jealousy	Denial of parental affection and sexuality. Repression of jealousy, anger etc. (resulting in pleasant, superficial relationships)	Consciously he identifies with a friendly adult, while hiding his unconscious identification as a rejected child trying to come between his parents
AG	Two-person or possibly three-person	Castration in a heterosexual relationship	Withdrawal and the adoption of an impotent, passive attitude	Man (monk) defending himself against the dangers of heterosexuality by self-castration
B1	One-person	Loneliness	Denial and attempted wish-fulfilment	—
CG	Two-person?	Loss of control of his aggression in an unstructured situation	Attempt to structure the situation possibly employing obsessional defences	
A3	Three-person at first, then part-object concern for his genital	Oedipal anxiety. Castration anxiety	Repression and denial, together with attempt at withdrawal. Anxiety breaks through, distorting reality and is countered by weak intellectual defence	Unconscious identification is with small child dreading castration in oedipal situation. Consciously he is a detached, intellectual adult
B2	Two-person with tendency towards three-person	Loss of control. Heterosexuality	Repressive and/or obsessional defences? Retreat to homosexual friendship. Denial of threat implicit in the situation	Unconsciously he identifies with a child frightened of his sexual feelings towards mother and turning to father to make him feel safe in relation to mother
BG	Two-person with three-person implications	Separation, rejection. Rivalry with male	Denial and overcompensation. Structuring of relationship with men into dominant and inferior roles	Unconsciously he is an angry, rejected little boy while consciously he attempts to feel a dominant male
C2	Two-person (sexual)	Inadequacy	Denial	Insecure identification with potent father
C1	Part-object?	Fear of the vagina	Intellectual displacement	—

D. *Personality assessment of male subject W, deduced from tachistoscopic record*

(1) *Dominant unconscious object-relations sought*

The concern appears to be with genital relationships though the record is so restricted that I think it possible that more primitive phantasy material might have been revealed in a psychiatric interview; however, I should think that such phantasies are pretty strongly walled off from consciousness. Oral material is lacking from the record.

(2) *Dominant anxieties*

Castration anxiety—particularly in relation to women. Sexual inadequacy. Loss of control of his aggression. Separation and rejection in the oedipal setting.

(3) *Defences and ego strengths*

(i) *Dominant defences (in order of their importance)*. Repression and denial of affect are his most prominent defences. Obsessional control (?) and isolation. Passive submission or withdrawal in oedipal situations.

(ii) *Types of defence employed to master different anxieties*. Repressions and denial result in generalized inhibition of fantasy and affect; he makes cautious, reserved, pleasant, superficial relationships though some indirect aggression leaks through. He denies rejection and loneliness. Although denial constitutes his main method of keeping control there may be some obsessional mechanisms at work too, and isolation is used.

He evades rivalry with men by withdrawal or by passive submission, or, alternatively, where the situation is structured, he can be dominating in identification with father. The support of male friendship helps him to tolerate the threats (largely castration?) of a heterosexual relationship, but he can only adopt a rather submissive, semi-potent attitude towards women.

(iii) *Defences and ego strengths*. (a) *How much does anxiety break through?* Defences seem to keep anxiety effectively at bay in a situation such as this. Although repression is at work, his need for control, structure and understanding drive him forward in the face of underlying anxiety and his ego is strong enough to cope. Although his defences contain his anxiety, some anger and dissatisfaction leak through in ways of which he is probably not aware.

(b) *Reality contact*. Good. He grasps the essentials well and does not bother about detail.

(c) *Freedom of fantasy and emotional expression*. Very little fantasy or feeling emerges. He makes the test an intellectual task, sticks to the essentials and reveals the bare minimum. This might be different in a structured situation. (I say this in view of his ego strengths which suggest to me that he must be capable of more fantasy and affect than are revealed in this test.)

(4) *Identification*

Consciously: I expect he can enjoy friendship with men and can also make some sort of heterosexual adjustment. The restriction of the record and superficiality of relationships suggest he suffers from depression, feelings of emptiness and inadequacy. In A1 he saw a man—'a silhouette...with something at the bottom...something else which dominates'. Perhaps this expresses his feelings about his superficiality and his hidden difficulties.

Unconsciously: he feels himself to be a rejected and angry child but also possesses the image of a good internal figure and can partly identify with the potent father. His sexual identity is undecided.

(5) *Diagnosis*

Hysterical character disorder (sexual inadequacy?). Good ego strengths and no obvious primitive problems.

E. *Comparison of the personality assessments derived from the perceptual data and from psychiatric interviews*

In order to compare the personality assessments derived from the two different sources of

data it was necessary to divide the subjects into two groups according to their sex. At first it had been hoped to obviate this division by disguising the subjects' sexes but although defences, ego strengths and diagnoses could be expressed without reference to the subject's sex, it was found impossible to express oedipal relationships and sexual problems accurately in such neutral terms. Consequently, for purposes of comparison, the data derived from the five male and five female subjects were considered separately.

Comparisons between the two sets of personality assessments were made by means of a matching technique and by qualitative inspection. We shall first consider the method and results of the matching technique before amplifying it with some description of the qualitative findings.

Two psychologists, N and O, were separately asked to take each psychiatric assessment of personality in turn and select the personality assessment derived from the perceptual data which most resembled it. Thus, for each psychiatric assessment there was a choice of five possible alternative records to match with it. Psychologist N completed the matching of the records of both male and female patients, but psychologist O, who had some knowledge of the female patients, was only available to match the male subjects. For this reason psychologist P made the second independent matching of the records of the female subjects. All three psychologists were asked to note the features of the records on which they had placed most reliance when making their choices.

The outcome of this matching procedure was that psychologists N and O paired all the personality assessments of the male subjects correctly, and psychologists N and P also achieved complete success in their matching of the assessments of the female subjects.

It is obvious from this result that a high degree of agreement existed between the two sets of personality assessments. However, the matches were not always easily made and although some of them were selected with

confidence, other matches were made with uncertainty and diffidence. Psychologist N reported a high degree of confidence in her matching of records for male subjects W and Z, moderate confidence for subjects V and X and some uncertainty about subject Y. Psychologist O felt very confident in her matching of the records for W and Y and moderately confident about the matching for subjects V, X and Z.

The matching of the personality assessments of the female subjects was a more difficult task on account of the greater degree of similarity between them (four of them were hysterics). Psychologist N matched the records for subjects B, C, D and E with some uncertainty, and for subject A with considerable hesitation. Psychologist P felt certain about her matching of the records for subject B, rather uncertain about the matching of subjects A, C and D, and most doubtful about subject E.

In what qualitative features of the two different sets of personality assessments did the agreement between them lie? Psychologists N, O and P reported that although they had sometimes been alerted towards a particular match by some small idiosyncratic feature present in two assessments, their final judgement was more confidently made on the basis of the overall degree of agreement. In the notes they made of the reasons for their choice they instanced good agreement between three or more sections of the report.

Examples of idiosyncratic features found in the assessments of one subject only are 'overeating as a defence' (subject D) and 'displacement of oral problems to the visual sphere' (subject Y). Such unique examples should be contrasted with the much more frequent finding of a particular type of object-relationship, anxiety or defence in several personality assessments; e.g. castration anxiety was mentioned in all the personality assessments of the male subjects, though its relative importance and its association with different object-relationships varied in each case. It should perhaps be mentioned that no deductions about personality dynamics were made from

chance remarks in response to the tachisto-scopic experiment, since the subjects did not, in fact, make any. For instance, the existence of over-eating as a defence was not deduced from subject D's referral to any special fond-ness for food, but from a strikingly unusual perceptual response—she first perceived card AG as 'a rough sea' then rapidly retreated to seeing it as 'a meringue—you know, a high pile, when they put meringue on top of some-thing, it's high—fluffy'.

In order to illustrate further the degree of correspondence between the two sets of personality assessments we give below the psychiatric assessment of subject W so that it may be compared with the same subject's personality assessment deduced from perceptual data (p. 9). As already mentioned, psycho-logists N and O both matched this subject's personality assessments with considerable confidence so that the comparison of these two assessments illustrates a highly successful degree of correspondence and cannot be con-sidered typical of the data as a whole.

F. *Personality assessment of subject W deduced from psychiatric interview*

(1) *Dominant unconscious object-relations sought*

Object-relations sought are on a genital level. There is a tendency towards a homosexual object choice to escape from oedipal anxieties but this solution is unsatisfying and hetero-sexual choices are made, though in his relations with women he soon finds that the good feelings he had at the beginning are poisoned by deeper feelings of anger and hate because of his rejection by mother. The object-relation choice is narcissistic.

(2) *Dominant anxieties*

Castration anxiety is by far the strongest. This is less in relation to his own sex than to women, where it is reinforced by anxieties deriving from pregenital impulses, oral (pro-jections) and anal-urethral. There is quite strong anxiety about loss of emotional controls.

Fear of rejection and separation is present, particularly when he faces his inability to solve his sexual problem.

(3) *Defences and ego strengths*

(i) *Dominant defences (in order of import-ance)*. Repression, denial of affect, indentifi-cation with aggressor, introjection, isolation, rationalization, and projection of aggression.

(ii) *Types of defence employed to master different anxieties*. Repression and rationali-zation are used in all situations. He defends himself against feelings of rejection and separation by denial of affect and rationaliza-tion. He projects his fury with mother (for rejecting him) to some extent on to the woman and dreads castration (cf. his ejaculatio praecox); even so, he can overcome this fear but is still forced to face the unprojected feelings. He then rejects her and withdraws from the relationship himself. However, he is forced to face the resulting isolation and need. At times he can evade castration fears with women by adopting a safe feminine role towards them. Castration anxiety from the male is dealt with by denial and by a combi-nation of displacement and identification with the aggressor; his own castrating wishes are projected.

(iii) *Defences and ego strengths. (a) How much does anxiety break through?* The defences are good enough to allow efficient functioning within a restricted field.

(*b*) *Reality contact*. Reality contact is good.

(*c*) *Freedom of fantasy and emotional expres-sion*. This tends (particularly in sexual situa-tions) to be on an all-or-none basis; there is quite strong anxiety about loss of emotional controls. The consequent defensive denial restricts his capacities considerably but where control is provided by the situation, he can use his rich fantasies.

(4) *Identification*

He is still unsure of his sexual identity; predominantly he feels himself an angry little boy liable to be rejected for his anger; alter-natively he adopts a feminine identification.

(5) Diagnosis

The picture is of a character disorder with hysterical features. There is a strong degree of narcissism. Ego strengths are good.

It will be observed from the comparison of subject W's two personality assessments that although each assessment contains some points unique to itself (e.g. narcissism and anxieties deriving from oral and anal-urethral sources occur only in the psychiatric assessment, while depression, emptiness and feelings of superficiality occur only in the perceptual assessment) there are no obvious points of disagreement. This was true of the comparison of the assessments in general; the two assessments of the same subject often contained some different points or emphasized the same points differently, but the assessments very rarely contained items which were incompatible or contradictory. Such contradictory points as occurred were in relatively minor issues (e.g. freedom of fantasy); only in one case did a more striking disagreement occur (subject E was judged psychotic by the psychiatrist while the psychologist wrote 'there seems to be no immediate risk of psychosis').

Psychologist M made a rough attempt to discover which sections of the assessments were most helpful in leading to correct matches. In order to do this she judged that the corresponding sections from the two assessments of one subject showed 'adequate agreement' when they contained more than one significant correspondence and no disagreements. An example of two sections which were judged to show adequate agreement is given below.

G. Subject Y. Dominant anxieties deduced from perceptual data

Castration, both by men and women. Heterosexual relationships are more terrifying than homosexual ones because of his greater destructiveness towards women. He has a particular fear of the vagina. Aggressive assertion—whether phallic or oral (greedy attack). He is also afraid of his anal sadism in the two-person relationship. Loneliness and loss of identity.

H. Subject Y. Dominant anxieties deduced from psychiatric data

Isolation and fear of losing both his own identity and contact with reality. Three-person situations lead to greater withdrawal and not to emulation or rivalry because the fear of the greedy heterosexual partner is even greater than that of the jealous and hostile male. Because of pre-oedipal problems he feels unable to cope with the aggressive feelings that the oedipal situation arouses in him.

These two sections were judged to agree adequately on account of the lack of contradiction between them and the mention by both of fears of isolation (loneliness), loss of identity and the presence of greater anxiety about heterosexual relationships than homosexual ones. (Moreover, hostility towards women and fear of them are closely linked dynamically, as are also fear of the woman's vagina and of her greed.) However, the two sections were not agreed on the relative importance of the different anxieties as revealed by the order in which they were given.

The number of agreements between the paired sections of the two sets of assessments was appraised and then tabulated as shown in Table 2.

Table 2. Number of adequate agreements

		Male subjects	Female subjects
1.	Object relations	4/5	3/5
2.	Dominant anxieties	4/5	4/5
3.	Defences (i) and (ii)	2/5	2/5
	Ego strengths (iii, a, b, c)	4/5	4/5
4.	Identification	2/5	2 5
5.	Diagnosis	3/5	4 5
	Total	19	19

It is clear that there is no significant difference between the findings for the male and female subjects. This seems to contrast with the greater difficulty experienced by the independent psychologists when matching the personality assessments of the female subjects. However, the problems of matching these

subjects lay not in a failure of correspondence between the two assessments of the same subject, but in the degree of similarity between the dynamics of the group of female subjects as a whole.

It will be observed that the pattern of agreements was uniformly good (i.e. above 50%) for sections 1, 2, 3(iii) and 5, and poor for sections 3(i) and (ii) and 4. It is possible that the low agreement on Defences (3 (i) and (ii)) was due to a real difference in the defences adopted by the subjects under the two different conditions. Inspection of the results makes it seem likely that the differences also depended on the nature of the appraisal made by the psychiatrist and psychologist M. Certainly differences of vocabulary were most marked in this section (e.g. the psychiatrist used the terms 'identification with the aggressor', 'introjection' and 'transient identifications' which were absent from the repertoire of defences used by the psychologist). The lack of agreement between the sections on Identification from the two sets seemed to be due to a failure to select similar items for inclusion under this heading. Probably a higher degree of agreement could have been obtained in the sections on Defences and Identification if the psychiatrist and psychologist had discussed their terms of reference with each other beforehand. It had been assumed that because they worked in the same analytical setting they would use the same vocabulary and theoretical concepts. The good degree of agreement between the two sets of assessments supports this initial assumption, but in retrospect we feel that there should have been a full discussion of the concepts and terms used before the analysis of the two types of data was made.

V. Conclusions

The result of this intensive study of ten subjects gives support to the general assumption that the perceptual process reflects the dynamics of personality. The extent to which it does so will depend upon the degree to which interpersonal issues are implicit in the total situation and in the immediate stimulus used: it will be modified by defensive opportunities, including familiarity with the situation and stimulus. In our experiment the clinical situation as a whole and the stimulus used were not familiar to our subjects; the extreme indefiniteness of the pictures and the short exposure time gave few perceptual clues and little opportunity for defensive work to be elaborated; in addition the clinical situation as a whole and the immediate stimulus in particular contained a great measure of interpersonal reference. Thus, according to our theory, would unconscious processes be emphasized. Under these conditions the influence of personality dynamics, in terms of an interpersonal theory of psychoanalysis, was identifiable with a fair degree of confidence.

Our method has pointed to a number of variables which are likely to affect the reliability of samples of perception. That these variables were adequately controlled is likely to have increased the possibility of a reasonably good match between deductions from the samples of perception and the independent personality assessments.

However, while some of the differences between the personality assessments obtained from the perceptual data and from psychiatric interviews are likely to be due to errors of judgement by either or both of the two assessors, and to some variations in the concepts they were using, other differences must derive from our imperfect control of the situational variables. Clearly some of the differences in emphasis on the various dynamic features of personality by the two assessors are likely to come from the nature of the immediate stimulus situation from which the data was obtained in each case; i.e. the brief tachistoscopic exposures with little reality content and little time to use it, and the extended experience of a psychiatric interview. This question will be further considered in a later paper when the tachistoscopic data are examined in comparison with O.R.T. responses, from the same subjects, obtained under the usual conditions.

If we are satisfied that we have obtained samples of perceptual process about which we know, with some certainty, the operative personality dynamics, it will be of interest to examine them in greater detail with reference to the particular stimulus values used, and in terms of similarities and differences between perception under tachistoscopic and normal conditions. Such a study may throw light on cognitive functioning and on perceptual defence.

Appendix

Description of O.R.T. pictures

(Order of presentation in parentheses.)

A1 (1) Single figure standing centrally, in 'misty surroundings' with some light patches and one dark patch of shading in lower left.

A2 (2) Two figures silhouetted from just below waist upwards, turned towards each other; light texture.

A3 (8) Single figure, left, separated by break in the shading from two figures quite close together on right.

AG (5) Vague group of three figures, bowed posture, on left; more definite group of three in right background.

B1 (6) Bedroom, rather bare, dressing table, bed, doorway in which there is a figure. Sharp black and white.

B2 (9) A large tree in black silhouette under which stand two figures, smaller black bush lower left, a house in background.

B3 (4) Two figures close together in dark silhouette standing in light doorway.

Figure in shadow, foreground right, in another doorway.

BG (10) Long white platform or terrace, two arches in one of which is single figure, in other a group of figures.

C1 (12) Cottage kitchen, table laid, sink, towel with red band flung over chair; vague figure in window. Other areas contain colour shading.

C2 (11) A largish figure in doorway of 'Victorian' type bedroom, vague outline of figure in bed. Colour shading and patches of colour in the room.

C3 (3) Interior of beamed room with fireplace, coffee table, books, ornaments on mantelpiece and incongruous red 'lamp'. Figure standing and two seated.

CG (7) Flight of steps in bright sunlight. Shadow of figure on top, at the bottom a group in which one figure has an arm raised.

References

Bruner, J. S. & Tagiuri, R. (1954). The perception of people. In G. Lindzey (ed.), *Handbook of Social Psychology.* Cambridge, Mass.: Addison-Wesley.

Bruner, J. S. (1951). Personality dynamics and the process of perceiving. (In *Perception: an Approach to Personality.* Ed. R. R. Blake and G. V. Ramsay. New York: Ronald Press.)

Carr, C. (1960). *The Prediction of Overt Behaviour through the Use of Projective Techniques.* Amer. Lect. Series, no. 415.

Fairbairn, W. R. D. (1952). *Psychoanalytic Studies of Personality.* London: Tavistock Publications.

Guntrip, H. (1961). *Personality Structure and Human Interaction.* London: Hogarth Press.

KLEIN, G. S., SPENCE, D. P., HOLT, R. R. & GOUREVITCH, S. (1958). Cognition without awareness: subliminal influences upon conscious thought. *J. Abnorm. Psychol.* **57**, 215–66.

KLEIN, M. (1948). *Contributions to Psychoanalysis, 1921–45.* London: Hogarth Press.

KLEIN, M. (1960). *Our Adult World and its Roots in Infancy.* London: Tavistock Publications.

PHILLIPSON, H. (1955). *The Object Relations Technique.* London: Tavistock Publications.

PHILLIPSON, H. (1962). *A Short Introduction to the Object Relations Technique.* London: Tavistock Institute of Human Relations.

VERNON, M. D. (1961). The relation of perception to personality factors. *Brit. J. Psychol.* **52**, 3, 205–17.

An attempt to measure an aspect of 'transference'

By A. H. CRISP

The body of knowledge accumulating from the study of psychological variables in therapeutics has been reviewed recently by Goldstein (1962), Kanfer (1961) and Lasagna (1962). The relationship between patient and doctor is one such important variable. The quality of this relationship is at least partially based on the transference of emotional attitudes into it from infantile sources. This latter concept of 'transference' derives from psychoanalytic theory (Freud, 1912) and attempts have also been made to explain it in terms of learning theory (Gliedman, Gantt & Teitelbaum, 1957). Some aspects of the 'transference' may be particular to the patient and the therapist but other factors, such as social class, are less specific. The initial attitude which the patient brings to the doctor, the 'transference potential', may now be susceptible not only to observation but also to measurement. For example, Knowles & Lucas (1962) constructed and standardized a scale designed to measure the conscious attitudes of a group of subjects to doctors. In this study they showed that there was a high correlation between the patient's recorded attitude to the doctor and the same patient's reported benefit from treatment.

Purpose of study

This study was aimed to develop a method of measuring some aspects of the attitude of the patient to the doctor. It concentrated on one area of the 'transference'; namely, the hypothesized identification of the doctor with an ideal father by the dependent patient. This has been examined, comparing this 'transference' attitude to general practitioners and psychiatrists, in three sub-studies: (1) by comparing two groups differing by social class; (2) in a group of psychoneurotic patients; (3) in three patients in a continuing therapeutic relationship, during which changes of attitude could regularly be assessed.

Method

A form of the repertory grid technique developed by Kelly (1955) and subsequently modified by Bannister (1960) has been adapted for the purposes of the study. This technique attempts to demonstrate relationships between certain concepts in an individual's mode of thought. As used by Bannister it has been shown to have a high coefficient of equivalence (an expression of reliability). He has also shown it to be a valid measure for his purposes. The test, in the present study, was used to measure attitudes to doctors. In any one patient these may vary from time to time and be sensitive to passing influences, especially contact with a doctor, e.g. during a test situation. Test–retest reliability studies were therefore not done. This study embodied an attempt to demonstrate, by the testing of predictions, the validity of the technique for assessing the patient's attitudes to the doctor and the changes which can occur in those attitudes. In adapting the technique a grid was utilized in which the individual was required to select as 'elements' 20 people whom he knew well. He was then asked to pick out 10 from the 20 who, in his opinion, most conformed to each one of the 36 different 'constructs'. A 'construct'[*] as used here is a descriptive label for a personal characteristic.

[*] Kelly defines 'construct' as basically 'a way in which at least two elements are similar and contrast with a third'.

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Selection of 'elements'

The 20 people selected as 'elements' by an individual were required to be adult in age. The subject was asked to write their names on separate small blank cards provided for the purpose. Ten of the people were of obligatory type: namely, the subject's father; the subject's mother; the subject's spouse or boy friend, etc.; the subject himself; the name of some rather frightening person; the name of some rather authoritarian person; the name of a good friend; the name of someone the subject disliked; the words 'ideal father' and the words 'ideal mother'. Some individuals found difficulty in bringing to mind appropriate figures in some of these cases but all eventually succeeded in doing so. It was hoped that this obligatory group of figures would provide a basis for a suitably diverse collection of 'elements'. The other 10 'elements' were people of their own choosing, 5 men and 5 women. They were then asked to number the cards 1–20, in any order they wished.

At this point they were reassured that the test did not involve them in disclosing to the investigator their attitudes to and feelings about the 20 people involved as 'elements'. They were told that all the tester wished to know, in each case, was the number attached to the person on the card and not the person's name. The 20 persons merely provided a scaffold on which to build a structure of their own ways of thinking.

Selection of 'constructs'

The 36 'constructs' were finally selected as being the most useful ones (i.e. the ones on which differences in score mainly depended), from an initial 80 'constructs' included in the grid in a small pilot study. The original 80 'constructs' had been selected because they were regarded as important, on the basis of clinical experience, in most patients' construing of doctors. Thirty-three of the final 'constructs' were related to common needs and personality traits (see Fig. 1). The remaining three key 'constructs' were whole-person 'constructs'; they were (a) 'ideal dependable father', (b) 'my G.P.', and (c) 'the psychiatrist' or, where the test was applied to patients, 'Dr so-and-so', the specific therapist about to treat them.

Instructions

Individuals to be tested were always told that 'the test is designed to get some idea of ways of thinking and feeling'.

They were asked to sit down at a desk with the 20 cards in front of them and told to pick out the 10 out of the 20 numbers representing individuals most conforming, in their view, with the first 'construct'. The 'constructs' were presented to them verbally and recorded one at a time; always in the same order (see Fig. 1). They could not see the list of 'constructs'. They were always told to use their own interpretation and understanding of the 'construct'; sometimes they needed to reflect on this. If they had any difficulty in selecting up to 10 persons for some of the 'constructs', e.g. the 10 most 'mean', then they were reassured that this was only a relative judgement that they were making, i.e. the 10 most 'mean' out of the 20 people before them. If they still had difficulty they were advised to consider the opposite of 'mean', as they comprehended it, e.g. 'generous', and to pick these 10 people and then call out the residual numbers. The following advice was always given concerning each of the three whole-person 'constructs'. 'Although these figures are usually male you may well decide that some of the female people on your cards possess more of the qualities consistent with these figures than some of the male people on your cards. Do not exclude these female figures from your selection unless it is important to you that you do so. The reverse should apply if your G.P. (or the psychiatrist about to treat you) is female.' Any spontaneous comments, made by the subject concerning his opinion of doctors, was noted.

The subjects were encouraged to select their cards by moving them around on the desk, into appropriate groups. Before each new

Fig. 1

'construct' was presented the subject was required to return the cards to a common pool.

Scoring of grid

Fig. 1 represents the grid as designed for the investigation. In the figure it is shown completed and scored. The method of scoring the grid is as follows. 'Matching scores' (Bannister, 1960) are calculated between each of the three whole-person key 'constructs' and all the other 'constructs'. For example, the line 'ideal dependable father' is compared with every other line (36 lines) and a 'matching score' noted—two dashes coinciding (vertically) represents a match, two blanks similarly coinciding represents a match, dash and blank or blank and dash is no match. Thus in Fig. 1, 'ideal dependable father' matched with 'tolerant' gives a 'matching score' of 18 out of 20 or +8 (i.e. +8 above a neutral 'matching score' of 10; the higher the + score, the closer is the association between 'constructs' and the greater the − score the greater the discrepancy between these 'constructs' in the subject's mode of thought). In the same way 'ideal dependable father' matched with 'contented' gives a 'matching score' of 14 out of 20 or +4 and matched with 'mean' it gives a 'matching score' of 4 out of 20 or −6, etc. Similarly, 'the psychiatrist' matched with 'tolerant' gives a 'matching score' of 16 out of 20 or +6, with 'contented' a 'matching score' of 12 out of 20 or +2, etc. Likewise, 'like my G.P.' matched with 'tolerant' gives a 'matching score' of 12 out of 20 or +2, matched with 'contented', a 'matching score' of 8 out of 20 or −2, etc. The full results are represented graphically (by ○, × and − in the respective cases of 'ideal dependable father', 'the psychiatrist', and 'my G.P.') on the page opposite the grid. Differences can then be scored between key figures, viz. 'ideal dependable father' and 'the psychiatrist' or between 'ideal dependable father' and 'my G.P.' by comparing their 'matching scores' on each 'construct'. Thus, in Fig. 1, the difference between the subject's construing of 'ideal dependable father' and 'the psychiatrist' on

the 'construct' 'tolerant' is 2 (the difference between +8 and +6); on the other hand, the difference between the subject's construing of 'ideal dependable father' and 'my G.P.' on this same 'construct' is 6 (the difference between +8 and +2). The sum of these comparative scores in each case (e.g. 42, comparing 'ideal dependable father' and 'the psychiatrist' over the whole range of 'constructs', and 106 when similarly comparing 'ideal dependable father' and 'my G.P.' in Fig. 1) represents the measure of the extent to which the individual's construing of 'ideal dependable father' diverges from his construing of the two doctor figures. It can only be a measure of such construing, however, within the limits of the 36 'constructs' presented. This total score is termed the 'transference score'. It was hoped that, in this study, a low 'transference score' would be shown to represent a 'positive transference' (i.e. when the subject regarded the ideal dependable father and the doctor figures in the same light) and a high 'transference score', a 'negative transference'.

It was hoped that one great advantage of this technique would be the means it provided of assessing attitudes to various doctor figures without the subjects being aware that the comparisons described above were being made. This expectation has, it is believed, been realized. This capacity of the test probably derives from two factors: first, the large numbers of 'elements' and 'constructs' involved and secondly, the indirect method of determining the final attitude score by means of the comparisons described above. Individuals were not in fact aware that their attitude to doctors was being assessed. The same factors militate against practice effect when the test is repeated—as in the longitudinal studies.

APPLICATION

Study I

The measure was applied to two groups differing by social class, to assess whether differences in their hypothesized 'transference'

attitudes to doctors (bearing in mind that only one 'transference' variable was in fact being studied) could be demonstrated by this method.

Subjects

The two groups comprised 10 'normal' social-class I people and 10 'normal' social-class III people. It was recognized that un-controlled variables would be entering into the study; for example, all those aspects of individual personality not dependent upon social class determinants. In addition, the two groups could not be precisely matched for sex and age. The criterion for 'normality' required that none of the subjects was having current medical treatment or had ever had formal psychiatric illness. The samples of 10 taken from each of the social classes was a small one and, in this initial study, an attempt was made to select homogeneous case material within these social classes rather than to truly sample each social class.

The 10 social-class I people were selected randomly from the appropriate inhabitants of two short roads of houses on a new housing estate. The group was composed of young, graduate, recently married, professional people between the ages of 27 and 35 who had just begun to purchase identical contemporary-styled terraced houses. They were six males and four females. This group was aware that the investigator was a psychiatrist and the investigator was equally acquainted at a near-neighbourly level with all of them. Between them they were on the panels of six general practitioners. The area is populated by people from all social classes. None of the 10 was aware, at the time of testing, that the others were also being tested.

The 10 social-class III people were selected from the 2000 clerical staff of a large nationalized organization. The 10 people were selected one by each of 10 executive officers acting independently and who selected one of his office staff on the basis that he regarded them as 'dependable and trustworthy long-term employees, average in personality, with no history of protracted sick leave, not currently

attending their doctors'. This group of people had individually been told previously that 'the investigator was a doctor from the Middlesex Hospital who was interested in and concerned with measuring thinking processes'. The ages of this group ranged from 21 to 46. They were five males and five females. Each member of this group was on the panel of a different general practitioner.

Predictions

The predicted differences between the 'transference scores' of these two groups were based on an admixture of personal clinical judgement and sociological data and hypothesis. The former was based mainly on past impressions of patients' attitudes to their G.P.'s and psychiatrists in relation to their social background. It was recognized that the social-class I group might be influenced in their construing of 'the psychiatrist' by their knowledge that the investigator was a neighbour as well as a psychiatrist.

A few sociological studies were found to have some indirect or tangential bearing on this study. Hollingshead & Redlich (1958) studied a New England urban population in respect of their attitude to mental illness. One of their many findings was that individual willingness to attend a psychiatrist when ill was directly related to social class. The lower the social class, the less willing were the group as a whole to seek psychiatric advice. (The criterion of social class used—Hollingshead's index of social position—can, for this purpose, be roughly equated to the Registrar-General's coding of occupation in this country.) In this study the social-class I and II groups were more prepared to accept psychiatric advice than the lower groups and tended to regard the psychiatrist as socially equal or inferior to themselves. The lower social class groups were found to have very little knowledge of or insight into the nature of mental illness. Patients from these latter groups often expressed their need for the psychiatrist to play a more authoritarian role in relation to them.

Other workers have studied the nature of

family structure and dynamics in relation to social class (Komarovsky, 1961; Bernstein, 1963). Bronfenbrenner (1961) surveys the literature in this field during the last 30 years; it is mainly American. The inference from these studies is that, broadly speaking, lower social-class families have a 'power' orientation in which the child can only react in a limited way, by withdrawal, submission or rebellion, to parental decisions. As a consequence, his subsequent social attitudes are 'status' orientated. He will tend to adopt a submissive dutiful attitude towards any socially superior authoritarian figure, especially if the latter is benignly disposed towards him. In contrast, the higher social-class families tend to have more permissive dynamic family relationships. The subsequent social attitudes of this group are more likely to be determined by 'person' rather than 'status' values. The 'personal' relationship, often involved in attending a psychiatrist, is not likely to be such a great threat to this latter group. In contrast, an individual from a lower social class may have difficulty in determining the correct nature of his expected role in relation to the psychiatrist. The authority structure is not clear-cut and he may feel that responses will be required of him which he is ill-equipped to provide. In the face of these he is likely to adopt a defensively hos-

tile attitude. He is much more at ease in his traditional relationship with his family doctor.

On the basis of this evidence the following predictions were made. That the group from social-class III would construe 'the psychiatrist' as less close (i.e. there would be a higher 'transference score') to 'ideal dependable father' than would the group from social-class I. That the social-class III group would construe their G.P. as closer (i.e. there would be a lower 'transference score') to 'ideal dependable father' than the group from social-class I. That the social-class III group would construe their G.P. more closely than 'the psychiatrist' to 'ideal dependable father' and that the social-class I group might do the reverse of this.

Results

During the applications of the tests the following spontaneous comments made by subjects, concerning the doctors involved in the test, were noted down. Subject no. 2— 'My G.P. is not much good'. Subject no. 4— 'I'm not very happy with my G.P.'. (Subjects nos. 2 and 4 had the same G.P.) Subject no. 15—'I've given my G.P. up'. Subject no. 17—'Psychiatrists give me the creeps'. Subject no. 20—'I don't go much on them' (psychiatrists).

Table 1. *Transference scores*

Social-class I group			Social-class III group		
Subject	G.P.	Psychiatrist	Subject	G.P.	Psychiatrist
1	74	130	11	94	110
2	302	62	12	90	92
3	96	74	13	84	154
4	184	94	14	40	118
5	114	100	15	286	84
6	110	112	16	64	154
7	106	42	17	108	176
8	108	82	18	56	200
9	122	94	19	78	132
10	120	76	20	112	222
Mean	133·6	86·6	—	101·2	144·2
S.D.	21·81	8·39	—	22·91	15·20

Statistical analysis

Two-tail tests were used throughout because of the tentative nature of the hypotheses and because they impose more stringent limits on levels of significance.

(1) The 'transference scores' in relation to the G.P. differed significantly between the two groups (0·05 level). Mann-Whitney U Test.

(2) The 'transference scores' in relation to 'the psychiatrist' differed significantly between the two groups (0·02 level). Mann-Whitney U Test.

(3) The 'transference scores' within the social-class I group for the G.P. and 'the psychiatrist' differed significantly (0·05 level). Wilcoxon Matched Pairs Test.

(4) The 'transference scores' within the social-class III group for the G.P. and 'the psychiatrist' did not differ significantly. However, if subject no. 15 was excluded then there was a significant difference (0·01 level). Wilcoxon Matched Pairs Test.

The direction of these statistically significant differences in score is consistent with and therefore confirms the hypothesized differences postulated in the first and second predictions. The two hypothesized differences in score, advanced in the third prediction, are partly substantiated by the results. Thus, in both these cases the trend of the results is consistent with the hypothesized outcome and, in the latter case, the difference in scores is statistically significant.

Study 2

The measure was applied to a group of psychoneurotic patients. The intention was to discover whether hypothesized differences of the 'transference' attitude to doctors, between this group and the preceding groups of 'normal' people, could be demonstrated by this method.

Subjects

The group of psychoneurotic patients comprised two subgroups. Five patients (nos. 21, 24, 25, 27 and 30) were out-patients who had seen a specific psychiatrist once with a view to

having behaviour therapy. They were all suffering with monosymptomatic phobias. The other five patients (nos. 22, 23, 26, 28 and 29) were in-patients. They were all suffering with neurotic depression and had been seen once by a specific psychiatrist with a view to commencing psychotherapy. These patients were only selected in the above respects and were otherwise consecutive cases entering the department. Each member of this group attended a different general practitioner. The observer was not involved in the treatment of any of the cases.

Predictions

The predicted differences between the 'transference scores' of the psychoneurotic group and the 'normal' groups were based on the following hypotheses:

(a) Psychoneurotic patients enter into a greater 'transference' relationship with the doctor than other patients. This group of psychoneurotic patients had come to doctors for help and so it was likely that their 'transference' feelings would be positive.

(b) These patients were about to enter a definite relationship with a specific psychiatrist whom they had already met once. They were not only acquainted with him but were dependent upon him for help. Psychoneurotic patients have frequently been observed to become very dependent on entering hospital.

(c) The patient's 'transference' attitude to his G.P. might be influenced not only by the fact that the G.P. had referred him on to the specialist but also that, in so doing, he had demonstrated his own relative inability to continue helping him himself.

On the basis of these hypotheses the following predictions were made. That the psychoneurotic group would construe both the G.P. and the specific psychiatrist attending them as closer to 'ideal dependable father' than the normal groups. Further, that they would construe the specific psychiatrist more closely to the 'ideal dependable father' than their G.P.'s.

Results

During the application of the tests the following spontaneous comments made by the subjects, concerning the doctors involved in the test, were noted down. Subject no. 25—'I have a very high regard for my G.P.'. Subject no. 26—'I don't get on very well with my doctor. I seem to get on very well with Dr so-and-so' (the specific psychiatrist).

Table 2. *Transference scores*

Psychoneurotic group

Subject	G.P.	Psychiatrist
21	110	42
22	152	76
23	82	82
24	86	32
25	38	60
26	194	40
27	32	46
28	108	74
29	72	72
30	76	66
Mean	95·0	59·0
S.D.	16·41	5·89

Statistical analysis

(1) Comparing the construing of the G.P. in the three groups there is no significant difference between the psychoneurotic group and either of the other two 'normal' groups. Mann-Whitney U Test.

(2) Comparing the construing of the specific psychiatrist by the psychoneurotic group with the two 'normal' groups' construing of 'the psychiatrist' there is a significant difference between the psychoneurotic group and both the social-class I group (0·02 level) and the social-class III group (0·001 + level). Mann-Whitney U Test.

(3) Comparing the construing of the G.P. and the specific psychiatrist within the psychoneurotic group, the differences are not significant. Willcoxon Matched Pairs Test.

These analyses only partly substantiate the predictions (i.e. second part of first prediction)

at a statistically significant level. However, in all cases the direction of the differences in scores between groups and within the group is consistent with the predicted outcome.

Study 3

The measure was applied to the study of the 'transference' aspects of a continuing doctor-patient relationship in individual patients undergoing treatment. The intention was to discover whether the measure would prove to be sensitive to trends and shifts in the 'transference' relationship as evaluated clinically. Three psychoneurotic patients, considered unsuitable for psychotherapy, and referred for behaviour therapy, were studied in this way.

Patient no. 1 was a 21-year-old girl with a phobia of large 'creepy' flying insects. She was extrovert, narcissistic and histrionic in personality and of above average intelligence. There were many sexual difficulties in terms of which the phobia appeared to be psychodynamically meaningful. She was treated, by the technique of relaxation and desensitization (graded exposure to the insects), and made a good recovery from her symptom.

Patient no. 2 was a 48-year-old woman with a chronic fear of loud noises. She was severely obsessional in personality with a history of recurrent depression; she was of average intelligence. The history revealed a number of childhood stresses centred around the unhappy marriage of her parents and her 'noisy' father's punitive attitude towards her. It was planned to treat this patient by relaxation and desensitization but she discharged herself from hospital at this time.

Patient no. 3 was a 56-year-old woman with gross obesity due to over-eating. The history of obesity went back 9 years. She was a severely anxious, phobic, obsessional person of average intelligence. Nine years previously there had been a marital upset leading to chronic sexual frustrations and depression in the patient—the over-eating appeared to be a defensive substitute gratification against these stresses. The patient was treated by aversion

therapy in respect of her eating with limited temporary success.

During the treatment period the patients were seen by the investigator at regular intervals, at the onset of therapy and thereafter, and independently of the behaviour therapist. On these occasions the patients were assessed clinically and by means of a rating scale in relation to their specific symptom under treatment and their total psychiatric state. Any comments that the patients made concerning the therapist were noted.

A decision was made on each occasion concerning the current state of the 'transference' relationship with the therapist. The following psychodynamic propositions were used.

(*a*) The initial attitude to the therapist would be favourable, i.e. the initial 'superficial positive transference' would be quite strong. This was based on the fact that these were psychoneurotic patients, keen to have treatment.

(*b*) So long as the therapist attended to and relieved the specific symptom and, provided no other symptoms developed, the initial 'transference' would become increasingly 'positive'.

(*c*) If, during behaviour therapy, other symptoms developed which were incapacitating and if the therapist did not attend to these, then this would be associated with a less 'positive transference'.

(*d*) If, for any other reason, the patient had cause to be offended by the therapist, then this would also be associated with a lessening of the 'positive transference'.

Patients' spontaneous comments concerning their attitude to the therapist were also taken into account.

Once the initial assessment had been made subsequent assessments were always compared with the preceding assessment. On the basis of this a prediction was made on each occasion concerning the nature of the 'transference score' that would emerge. The prediction was only concerned with the relationship of this score to the preceding one, i.e. whether it would be a larger or smaller 'transference score'. Thus an assessment that the

'transference' was more positive than at the time of the previous assessment led to a prediction that the 'transference score' would be lower than last time and vice versa. The patient was then immediately tested on the grid.

Results

In a total of fourteen applications of the test to these three patients, the prediction was correct thirteen times.

Two of the patients initially showed a very strong 'positive transference' to the therapist both clinically and as measured on the grid (initially 'transference scores' of 32 and 40 respectively). These two patients both subsequently revealed a capacity for holding intensely hostile attitudes to doctors. Thus patient no. 2 suddenly became unreasonably angry and resentful during the period of assessment for behaviour therapy. She accused the therapist of deliberately attempting to upset and frighten her by playing a tape recording of loud noises in an adjacent room, and discharged herself. Patient no. 3 became very angry with the therapist when he persisted in concentrating his treatment on her eating habits at a time when other symptoms of a hypochondriacal and depressive nature were emerging. These hostile attitudes in both cases were again reflected in the 'transference scores' (250 and 182 respectively). The further details of this study are described elsewhere (Crisp & Meyer, 1964).

DISCUSSION

It is known that the relationship between patient and doctor may be a complicated one based on the interaction of realistic, cultural and neurotic attitudes of the patient and the doctor. These three components contribute to the relationship to a varying extent. Variations may be observed clinically during a continuing doctor–patient relationship. The relationship also varies considerably from case to case depending on the background and personality of the patient and doctor.

This study has been concentrated on certain

Table 3

(↑ = More positive transference than at previous assessment (i.e. lower 'transference score' predicted). ↓ = Less positive transference than at previous assessment (i.e. higher 'transference score' predicted).)

Days treatment	...	0	4	8	12	16	20	24	28	32	36	40	44	48	52	56	60	64	68	72	76	80	84	88	92	96	100	Predictions Correct	Incorrect
Patient 1	Clinical assessment of 'transference'		↑	↓																									
	'Transference score'	102	66	80				58				40																4	0
Patient 2	Clinical assessment of 'transference'		↓																										
	'Transference score'	32	250																									1	0
Patient 3	Clinical assessment of 'transference'		↓ ↓	↑	↑					↑	↑					↓												8	1
	'Transference score'	40	72	110	70					72	46					70		90		182		64						13	1

'transference' aspects of the relationship. The initial neurotic attitude or 'superficial transference' of the patient towards the doctor may change both quantitatively and qualitatively with time. Psychodynamic hypothesis, concerning the nature of 'transference', often proposes that people initially tend to identify the doctor with their concept of an ideal father and enter into a dependent relationship with him. The original idealization of the father is regarded as being a neurotic defence (reaction formation) elaborated in childhood as part of a necessary defensive denial of feelings of intolerable and untolerated hostility towards the father. So long as the needs of this neurotic attitude are met by the (omnipotent) doctor the patient may be relieved of some anxiety. This phenomenon forms part of the 'placebo effect' (Lasagna, 1962), contributes to 'transference improvements and cures' (Alexander, 1956; Fenichel, 1946; Kolb & Montgomery, 1958) and may be important in behaviour therapy. In the present study this hypothesized basis of the neurotic attitude has been incorporated, as the major theme, in a test designed so as to provide some measure of this aspect of the doctor–patient relationship. The basic technique of the test has previously been shown to provide a reliable and valid measure for other purposes (Bannister, 1960). The study was concerned to examine the validity of the test in respect of this particular measure. It was therefore always applied, in the three substudies described, in the light of predictions concerning the results. These predictions were based variously on sociological data, psychodynamic hypothesis and personal clinical judgement. The results, except for the one instance in Study 3, were always differentially consistent with the predictions.

Study 1 was concerned with the examination of two groups of people differing particularly in their social, occupational and educational background. Some predicted differences were confirmed of the way in which these two groups construed their family doctors and 'the psychiatrist', within the limits of the test structure.

In an attempt to study other variations in the relationship the test was applied to a group of psychoneurotic patients attending hospital. Predicted differences between the 'transference scores' of this group and the 'normal' groups were again confirmed.

The variables considered to be impinging on and modifying the 'transference' relationships in these groups have been enumerated. The groups were too small and too many different factors were operating to permit confident conclusions to be made concerning the relative importance of the respective variables in their contribution to the differences. Further studies, in which the level of neuroticism is quantified and studied under controlled conditions and in differing social classes, in relation to this measure of the 'transference', both when subjects are healthy and ill, would be useful.

The psychodynamic hypothesis concerning the nature of 'transference' postulates a potentially bipolar attitude by the patient towards the doctor—either of excessive respect and submission or else excessive hostility and defiance. The two cases in Study 3 whose 'transference' changed so dramatically both clinically and as reflected in the 'transference score', lend some support to this view. It gains some further support from a study of the 'transference scores', in relation to the family doctor, obtained in Studies 1 and 2. Thus, the scores ranged from 32 to 302. The majority were below 125 and only one score fell in the 'intermediate' range of score between 125 and 175. The initial hope that the test would prove to be an indirect measure of subjects' and patients' attitudes and that, as such, it might be eliciting less socially conscious and more intrapersonally meaningful attitudes was sustained by the fact that none of the testees discerned at any time the hidden purpose of the test.

The three patients studied longitudinally in Study 3 have only been reported on briefly and in so far as the results testify to the validity of the measure. The full study and results are published elsewhere. They support the

view (Meyer & Gelder, 1963; Oswald, 1962) that patients who electively reach treatment are likely initially to contribute favourable attitudes to doctors in their specific relationship with the therapist. To this extent, as Oswald suggests, the relationship must be regarded as important since hostile attitudes may prevent the patient from attending the doctor at all. During the treatment periods, the continuing relationship with the therapist appeared to be very sensitive to the patient's level of improvement or deterioration as assessed clinically and by the 'transference score'. It was not possible in this study to determine whether fluctuation in the 'transference' preceded or derived from changes in the clinical state. An attempt is now being made to study this problem.

The grid, as used in this study, presents a number of obvious limitations. Although the final 36 'constructs' were derived from a pilot study as the ones which were generally most significant in the individual's construing of doctors, it may be that some essential 'constructs' were not included. It may be that for some subjects the concept of a doctor figure centres mainly on just one or two of the subordinate 'constructs' and that, in this test, large divergent scores on these 'constructs' would be submerged in a low total score. In fact, during the study, this did not happen. It became apparent that some of the 'constructs' were generally less important than others. Thus, when there was a divergence in the scoring it was usually the consequence of fairly evenly distributed differences in the 'matching scores' on about 20 of the 'constructs', almost always the same ones. In the longitudinal studies, changes in the measure of the relationship were again mainly dependent on changing 'matching scores' with these 'constructs'. These 20 were: 'loveable', 'fussy', 'I trust', 'sense of humour', 'religious', 'enjoy life', 'selfish', 'conscientious', 'best sexual partners', 'strict', 'reliable', 'fond of children', 'scrupulous', 'I dislike', 'I feel relaxed with', 'ideal dependable father', 'aggressive', 'make most satisfactory spouses', 'depressed' and 'intelligent' (latter 'construct' important for

social-class I group). The 'constructs' which most consistently had the highest 'matching score' with 'ideal dependable father' were: 'sense of humour', 'best sexual partners', 'make most satisfactory spouses', 'I feel relaxed with', 'affectionate', 'scrupulous' and 'reliable'.

It was thought that masculinity might be a limiting 'construct', in the overall construing of the key figures, for some subjects. It was with this in mind that the special advice was given with each of the three special 'constructs', each time the test was applied. In fact, the general practitioners, in cases nos. 2, 4 and 13 were women, as were the therapists in cases nos. 23 and 24. Again, any importance that this factor had did not prevent the distinct intergroup differences in the construing of doctors. In addition, unfavourable construing of the doctor was frequently associated with a negative 'matching score' between the 'construct' of the appropriate doctor figure and 'ideal dependable father'.

The measure appeared to be an accurate one in that predictions of the results were almost invariably correct. The results also correlated highly with the individuals' spoken comments concerning their attitudes to doctors and, in the case of the patient group, to what was clinically observable. Outspoken and observable hostility towards the doctor was usually associated with scores between 200 and 300 points (these were the highest scores obtained in the study) out of a potential discrepancy of 720 points. There was never a case in which there was a completely negative 'matching score' between the key 'constructs' and any one other 'construct'. The test score is, of course, very largely dependent on the way in which the subjects construe the key 'constructs' of 'ideal dependable father', 'Dr...', etc. There may have been conscious or unconscious manipulation of these scores by the subject depending on whether they needed to please or indirectly express hostility towards the tester. If any such tendency existed it appears to have been fairly consistently expressed within the framework of the

separate groups and also in the individual longitudinal studies. It is anyway probably an essential aspect of some subjects' attitude to doctors.

As it stands the test takes between $1\frac{1}{2}$ and $2\frac{1}{2}$ hours to apply and score. It can probably be made less time-consuming and more sensitive by reducing the number of 'constructs' from 36 to the 20 which emerged as most useful in this study (Crisp, 1963).

Such a test as this probably has a variety of research applications. It may also prove a useful clinical tool; for instance, in the selection, for supportive treatment (e.g. supportive psychotherapy) of the one therapist of several judged, on the test, to have been most appropriately construed by the patient for the role.

SUMMARY

The relationship between patient and doctor is important in treatment. An attempt has been made, in three studies, to measure an attitude ('the transference score') of some subjects and patients towards doctors. The method is based on a modification of Kelly's repertory grid technique. It focuses on the comparison of the individual's concept of 'ideal dependable father' and his or her concepts of various doctor figures. The nature of the technique is such that the subject is unaware that this comparison is being made. Predictions, first concerning differences in 'transference score' between two social groups differing by class and a group of psychoneurotic patients entering treatment, and secondly concerning changes in 'transference score' in a group of psychoneurotic patients during treatment, have largely been fulfilled and the measure appears a valid one. Criticism and possible uses of the technique are presented. It is suggested that such a measure might provide a means of studying the significance of the relationship in therapeutics and its importance in the management of various types of psychiatric and other illness.

REFERENCES

ALEXANDER, F. (1956). *Psychoanalysis and Psychotherapy*. New York: W. W. Norton.

BANNISTER, D. (1960). Conceptual structure in thought-disordered schizophrenics. *J. Ment. Sci.* **106**, 1230–49.

BERNSTEIN, B. (1963). Personal communication. Institute of Education, University of London.

BRONFENBRENNER, U. (1961). *Readings in Social Psychology*, pp. 400–25. Ed. E. E. Maccoby, T. M. Newcom and E. L. Hartley. London: Methuen.

CRISP, A. H. (1963). Development and application of a measure of transference. *Read to Ann. Conf. Soc. Psychosom. Research, London*, 1964.

CRISP, A. H. & MEYER, V. In the Press.

FENICHEL, O. (1946). *The Psychoanalytic Theory of the Neuroses*, p. 559. London: Routledge and Kegan Paul Ltd. 1960.

FREUD, S. (1912). *The Dynamics of the Transference. Standard Edition of the Complete Psychological Work of Sigmund Freud*, vol. XII. London: Hogarth Press. 1958.

GLIEDMAN, L. H., GANTT, W. H. & TEITELBAUM, H. A. (1957). Some implications of conditioned reflex studies for placebo research. *Amer. J. Psychiat.* **113**, 1103–7.

GOLDSTEIN, A. P. (1962). *Therapist–Patient Expectancies in Psychotherapy*. London, New York: Pergamon Press Inc.

HOLLINGSHEAD, A. B. & REDLICH, F. C. (1958). *Social Class and Mental Illness*. New York: John Wiley and Sons Inc.

KANFER, F. H. (1961). Comments on learning in psychotherapy. *Psychological Reports*, **9**, 681–99.

KELLY, G. A. (1955). *The Psychology of Personal Constructs*, vols. 1 and 2. New York: Norton.

KNOWLES, J. B. & LUCAS, C. J. (1962). The contribution of attitude and personality to the patient's rating of treatment. *Proc. R. Soc. Med.* **55**, 778–80.

KOLB, L. S. & MONTGOMERY, J. (1958). An explanation for transference cure: its occurrence in psychotherapy and psycho-analysis. *Amer. J. Psychiat.* **115**, 414–21.

KOMAROVSKY, M. (1961). *Household Decision Making*, pp. 265–80. Ed. H. N. Foote. New York: University Press.

LASAGNA, L. (1962). Psychological effects of medication. *Proc. R. Soc. Med.* **55**, 773–6.

MEYER, V. & GELDER, M. G. (1963). Behaviour therapy and phobic disorders. *Brit. J. Psychiat.* **109**, 19–28.

OSWALD, I. (1962). Induction of illusory and hallucinating voices with considerations of behaviour therapy. *J. Ment. Sci.* **108**, 196–212.

A note on the origin of male homosexuality

By W. RONALD D. FAIRBAIRN

In Freud's *New Introductory Lectures on Psychoanalysis* we read 'After weaning has taken place the penis inherits something from the nipple of the mother's breast'. It is the thesis of this paper that the substitution of the penis for the breast provides the essential basis of male homosexuality.

The thesis in question will be illustrated by an account of the case of a man whom I have described as 'Morris' in a previous communication, and who, although hardly an overt homosexual, nevertheless displayed a strong homosexual tendency. Thus he sometimes had a bath in the presence of a male friend; and, although it would be an exaggeration to say that in these circumstances mutual masturbation occurred, there was penis-play in which Morris adopted a predominantly passive role, and in which it was not uncommon for him to have an emission. He also had frequent homosexual dreams and masturbation phantasies.

Morris was the only son in a family of four; and he was seven years younger than his youngest sister. In the circumstances I think there can be no doubt that he was an unwanted child; and, doubtless partly for this reason, he became his mother's favourite as the result of a process of over-compensation. His mother was an overbearing and possessive woman who domineered over the whole family, 'castrated' her husband and was always quarrelling with her daughters. Morris was completely dominated by her.

When he first went to school he suffered from a marked degree of separation-anxiety and insisted on his mother leaving the front door open. It would appear, however, that his mother kept the door closed most of the time while he was at school and only opened it just before she expected him back; for one day, on returning home unexpectedly early, he

found the door closed—a discovery which occasioned him great distress. As time passed, however, he began to find that life at school with other boys provided him with a welcome escape from dependence upon his mother. Later, when he joined the Army during the Second World War, he found in the Army another welcome escape from dependence upon his mother, in whose house he had continued to live after leaving school. His sisters incidentally had meanwhile married, so that for several years previous to his joining the Army he had lived alone with his mother, his father being by this time dead. The Army, as already indicated, provided him with a welcome escape from dependence upon his mother; and he enjoyed the all-male companionship of Army life. However, this enjoyment was in due course seriously impaired; for he was severely wounded in the left leg and taken prisoner at Arnhem. His wound was so severe that his leg had to be amputated in a German hospital. The amputation represented for him a castration; and unconsciously he regarded this castration as having been inflicted by his mother as a punishment for his deserting her in favour of a life in the Army with other men. When in due course he was repatriated, he experienced acute anxiety in the train which was carrying him home to his mother; and it was undoubtedly the prospect of returning to his mother that occasioned his anxiety. For his mother represented for him an arch-castrator.

So far as the situation prevailing in Morris's infancy could be reconstructed in analysis, it appeared that his mother showed great lack of understanding over the feeding situation. She appears to have been a disciplinarian over suckling and to have been rigid over times of feeding. Thus, if Morris cried, he was allowed

to go on crying until the set time for his being picked up arrived. It would appear also that his weaning from the breast was traumatic. After weaning he sought to console himself for loss of the breast by indulging in infantile masturbation. The significance of this fact is that he substituted his own penis for his mother's breast. It was this substitution that determined his selection of the penis as a sexual object instead of the female vagina, and that determined his homosexual tendency. As he said himself on one occasion 'I made my penis into a breast'; adding 'I could not have existed if I could not have had recourse to my penis as a substitute breast'. In accordance with these remarks it became evident that the role of castrator which he ascribed to his mother was related to the experience of weaning. Just as his mother denied him her breast when she weaned him, so, he believed, she denied him his penis as a substitute breast. This belief was borne out by the reproofs which she administered to him for masturbating in childhood.

In spite of his mother's warnings Morris continued the practice of masturbation. Eventually, however, he developed a para-phimosis, doubtless as the result of his retracting his prepuce in the process of masturbation; and the consequence was that he was circumcised. His exact age at the time of the circumcision is difficult to determine; but probably he was about five years of age at the time. Needless to say, the circumcision represented for Morris a castration; and it presented itself to him as a castration, not by his father, but by his mother. This 'castration' had the effect of reviving the trauma of weaning. Just as in weaning him his mother deprived him of the breast, so in the circum-

cision she appeared to be attempting to deprive him of his penis, which had become a substitute for the breast. The circumcision also presented itself as a punishment for his resorting to his penis as a substitute for the breast in masturbation; and it led Morris to fear a still more drastic punishment—an apprehension which he felt to be realized when he lost his leg. The circumcision created such anxiety that he stopped masturbating. However, at the age of twelve he was initiated by another boy into the practice of mutual masturbation; and thereafter the interrupted practice of solitary masturbation was resumed, accompanied by homosexual phantasies.

A marked feature of Morris's case was his fear of women, who presented themselves to him essentially in the role of castrators. The real castrator was, of course, his mother; and we have seen how he tried to escape from her in the castrating role. We have also seen how she always seemed to catch up on him, as when he lost his leg at Arnhem. His fear of castration by his mother was related to his valuation of his own penis as a substitute for the breast; and he was afraid of being deprived of his penis by his mother, just as in the weaning situation he had been deprived of the breast by her agency. He made his own penis a substitute for the breast; and this led to his regarding the penises of other men as sexual objects in preference to the female vagina, which he felt to be castrating in virtue of the fact that his castrating mother was a woman. It is thus that his homosexuality arose.

This paper is concerned solely with the origin of male homosexuality; but it may be surmised, on the basis of analogy, that the origin of female sexuality lies in a substitution of the clitoris for the breast.

Percival Lowell and the canals of Mars

By CHARLES K. HOFLING*

The motivations which determine scientific endeavour, or cause the investigator to apply himself to a given problem, or affect the way in which problems and data are perceived, organized and reported, have attracted considerable recent interest. The present paper considers the case of a famous and dedicated investigator whose reports seized the imagination of masses of intelligent laymen and resulted in a major scientific controversy.

I

Of Percival Lowell's famous book, *Mars and Its Canals*, published in 1906, a distinguished modern astronomer (Moore, 1954) has written: 'It is safe to say that no other scientific volume ever produced has given rise to so much argument.' (Lowell's first book on the subject, *Mars*, was published in 1895; it was considerably less detailed than the second and less widely read.) There is the likelihood of the question as to the nature of the various surface features of Mars being soon resolved beyond the possibility of doubt, and, even at the present time, the accumulated evidence on the subject is sufficient to produce a consensus differing from Lowell's opinion among nearly all observers. Yet such was the impact of Lowell's personality and work that for over half a century the argument raged, and it is not yet quite extinguished. In 1953, the previously quoted authority felt obliged to write: 'The canals...need explaining. Though Lowell's theory of intelligent beings (on Mars) has not a scrap of proof, we cannot dismiss it entirely.' V. M. Slipher has repeatedly—and as recently as 1962—spoken out in favour of the reality of Lowell's observations.

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The story of the canals of Mars goes back to the latter part of the last century. On the occurrence of three oppositions of Mars in 1877, 1879, and 1881, Giovanni Schiaparelli, an Italian astronomer of high reputation, drew charts of the planet definitely superior to any previously in existence. On these charts appeared a number of long, narrow, straight markings, running from one dark area of the planet to another, which, indeed, looked unlike anything previously noted in the planetary system. Schiaparelli, called them *canali*, that is to say, *channels*. In English translations of his early papers, the word became *canals*, and thus it has, for the most part, remained. Schiaparelli never committed himself to any theoretical position with respect to the origin of the features he had discovered. His own observational work ceased in 1890 because of failing eyesight.

During the 1880's the Italian's work received some corroboration by both English and French astronomers, and by the early 90's it was widely—although by no means uniformly—agreed that there was a set of linear or quasi-linear markings on Mars.

During the decade 1883–93, Percival Lowell divided his time between Boston and the Far East, travelling to Japan and Korea in the role of what nowadays would be called a cultural anthropologist. He wrote of what he saw, and his several monographs were widely acclaimed.

During the latter portion of his decade of study of Far Eastern life and practices, Lowell became deeply interested in occult phenomena, in particular those connected with Esoteric Shintoism. His last visit to Japan had as its primary object the investigation of Shinto mysteries. In his book, *Occult Japan*, Lowell describes in fascinated detail exhibitions of immunity from physical injury: walking over

beds of hot coals, climbing ladders made of sword blades, and the like.

For some years Lowell had had an intelligent amateur's interest in astronomy. On the occasion of his visiting Japan for the purpose of studying Shintoism, he had taken with him a six-inch telescope. Nevertheless, Lowell's letters, his recorded conversations, and his publications gave every evidence that he had found his area of life work in the study and interpretation of oriental cultures and perhaps in governmental work in connexion with these interests. Yet, in the fall of 1893, Lowell suddenly left Japan, never to return; he came back to the United States and entered the field of astronomy, determined to carry on Schiaparelli's work.

During the ensuing year, Lowell moved with great speed and energy. Mars was again coming into opposition, and Lowell immediately fitted out an expedition to study it. He settled on Flagstaff, Arizona, as the location for the establishment of a private observatory. Observational work was under way by the spring of 1894.

By the end of the year, Lowell wrote that among the 'chief results' of his observations was: 'the detection of the physical characteristics of the planet Mars to a degree of completeness sufficient to permit the forming of a general theory of its condition, revealing *beyond reasonable doubt* first its general habitability, and second *its particular habitation at the present moment by some form of local intelligence.'* Lowell was at this time thirty-nine years of age.

Truly an astounding performance! A highly gifted man in early middle age, with an established career, turning suddenly to a seemingly remote field for which he has had quite modest preparation, plunging all of his time, energy, and material resources into this field, and, within a matter of months of actual work, expressing in dogmatic terms a sweeping and almost certainly incorrect conclusion which he was to defend with vigour and tenacity and without modification for the rest of his life.

* Italics mine, C. K. H.

II

Since no appraisal of what Lowell thought he was seeing through his telescope and of the deductions he based upon his sensory impressions can be made without reference to actuality, it is relevant briefly to state the best informed current views as to the major topographical features of the planet Mars (Moore, 1954).

Seen through a telescope of moderate size, Mars appears as a reddish ochre disk upon which are darker bluish green patches. The configuration is permanent, and therefore actual maps can be drawn of the Martian surface. The reddish ochre areas are generally considered to be deserts of some sort. The bluish green areas are less easily accounted for; they may be due merely to the accumulation on low-lying regions of a particular kind of mineral dust: on the other hand, many authorities consider it possible that they are caused, at least in part, by vegetation.

Mars has seasons not unlike those on earth, although the mean temperature is perhaps 40° lower. At the appropriate seasons, each polar region is seen to be covered with a white deposit which vanishes at the opposite seasons. These white areas are widely considered to represent ice, probably in the form of snow and/or frost.

Then there are the *canali*. These are also permanent features, but difficult to observe. In effect, they amount to some twenty or thirty thin streaks criss-crossing the planet's surface. These features are, for the most part, not photographable in a satisfactory way, since they are so fine as to be obscured by atmospheric perturbation during a time exposure. Recent observations made by one of the world's leading planetary observers, Dr A. Dollfus, working under ideal atmospheric conditions at the Pic du Midi Observatory in the French Pyrenees and using a twenty-four inch telescope, indicate that the linear features can, in some instances, be resolved into a series of spots and patches, roughly aligned. These spots and patches are thought to consist of naturally formed, narrow, shallow depressions. During the Martian spring, the *canali* appear to darken.

III

In presenting Lowell's picture of affairs on Mars, one should, of course, distinguish

between what he represented to be observed data and what he considered to be reasonable inferences from these data. Based upon the full exposition of his ideas in *Mars and its Canals*, the following list comprises the principal features which Lowell considered observational.

(1) Mars is covered with a network of lines 'of individually uniform width, of exceeding tenuity, and of great length. These are the Martian canals.'

(2) These lines are 'joys of geometric beauty; they look to have been laid down by rule and compass.'

(3) 'Interdependence, not independence, marks the attitude of the canals. Each not only proceeds with absolute directness from one point to another, but at its terminals it meets canals which have come there with like forthrightness from other far places upon the planet.'

(4) The total number of canals is great (being eventually represented as several hundred).

(5) At times, one observes a doubling of certain of the canals. What has appeared as a single line appears suddenly as a pair of parallel lines ('gemination').

(6) The course of the canals always or almost always lies along one of the 'great circles' of the planet, i.e. taking the shortest route between two points on a sphere.

(7) Small, dark, circular areas are usually to be seen at the crossing or juncture of canals; these are termed 'oases'.

(8) In general, the canals were seen to darken in the spring and fade in the late summer, but 'each canal had its own times and seasons for showing or remaining hid. What dated the one left the other unaffected.'

From observations such as these, Lowell said that he had constructed the following theory.

Mars is an 'old planet'; that is to say, it has followed a course of development and decline similar to that being followed by the earth, but is farther along this course. At the present time, the overriding problem for any form of life on the planet would be its aridity. This dryness would be an intensely serious threat to the food supply of any high form of life.

The number, placement, and geometrical perfection of the canals make it 'at once evident that (they) are not fortuitously placed', and, in fact, that they must represent an engineering project of a magnitude not even faintly approached on earth. This project has been designed to meet the threat of insufficient water. The darkening effect is due to the annual springing into life of irrigated strips of land lying alongside of the canals proper (which cannot actually be seen). The canals must be some form of huge closed conduits. The phenomenon of gemination represents the diversion of water into parallel conduits with the attendant watering of parallel strips of land. The oases are larger irrigated areas. The polar water is forced through the canal system by pumps; hence it is that the progressive darkening along a canal can move regardless of the terrain.

All of this makes it a reasonable and, in fact, a necessary inference [Lowell said] that Mars, being an older planet, has evolved a form of life superior to our own in intelligence and resourcefulness. Since the canals are currently in operation, this form of life exists at the present time.

IV

Turning now from the phenomenon of Mars to the phenomenon of Lowell, how is one to describe the sensory impressions and the convictions which comprised this portion of his behaviour?

Although diagnostic terms do not take one very far into the problem, they may serve as a starting-point. A number of Lowell's sensory impressions may, I think, be fairly categorized as illusory. That there was environmental stimulation (the roughly linear streaking of the spots and patches, for example) there can be no question. That this stimulation has been generally inadequate to produce the sensory impression that it produced in Lowell is also beyond question.

3-2

What is one to say of the conviction that Mars is inhabited by an ancient, intelligent race of super-engineers? Phenomenologically, this conviction appears to be rather close to a delusion, as the term is conventionally defined. Yet several factors require one to be cautious here. In the first place, while Lowell's was decidedly a minority opinion, it was never the opinion of a minority of one. Secondly, the conviction is not, to a serious degree, contrary to the observed facts; it is merely unsupported by them. Thirdly, as presented in Lowell's books, the conviction rests upon a series of inferences whose internal consistency and whose connexion with at least some of the observable facts involves the application of a highly rigorous logic. No; although it is close, the term, *delusion*, seems not really to fit; perhaps the expression, *idée fixe*, is more like it.

In this phenomenological glance at Lowell's position, it becomes of some interest to inquire which came first, the illusion(s) or the *idée fixe*.

Biographical data thus far available do not support any firm conclusion on this point. However, two features make one incline to the view that the idea came first: (1) The whole manner of Lowell's quitting the Far East and rushing to establish his observation post is suggestive of a man in the grip of a powerful idea. (2) The style and logic of *Mars* and *Mars and its Canals* have a smooth and inexorable quality. Doubts, questions and alternatives are handled with a facility which seems unlikely if the observations had come first and the conclusion(s) had gradually dawned. Take it all in all, one is left with the strong impression that Lowell 'knew' what would be found before he reached Flagstaff.

V

There is no doubt but that the Martian theories were of greater emotional significance than that which could be attributed to the usual pride of scientific discovery. To attest to this is Lowell's extremely energetic manner of plunging into the field, previously described. There are other pieces of evidence on this point. One is the intense and highly dramatic style of writing of the two books, *Mars* and *Mars and its Canals*, particularly the former, in which this note is struck in the very first sentence.

Once in about every fifteen years a startling visitant makes its appearance upon our midnight skies—a great red star that rises at sunset through the haze about the eastern horizon, and then, mounting higher with the deepening night, blazes forth against the dark background of space with a splendour that outshines Sirius and rivals the giant Jupiter himself.

Another interesting point in the manner of writing of the book, *Mars*, is the way in which the author's extreme eagerness occasionally breaks through inadvertently, causing him to express himself in a fashion which anticipates what is to come later in an orderly way. Thus, long before the sequence of inferences has been built up to the point at which the question regarding higher forms of life could be logically introduced, one finds the following sentence:

In the last chapter we saw how badly off for water Mars, to all appearances, is; so badly off that inhabitants of that other world would have to irrigate to live.

At times the effect is such as might almost be described as hypomanic.

...conditions must be such that in the Martian mind there would be one question perpetually paramount to all the local labour, women's suffrage, and Eastern questions put together—the water question.

That Lowell's work at Flagstaff was not undertaken in a spirit of unbiased inquiry is plain from some of his letters. Thus, to his mother, on 2 September 1894:

But the number of canals increases *encouragingly**—in the Lake of the Sun region we have seen nearly all of Schiaparelli's and about as many more.

* Italics mine, C. K. H.

At least two aspects of the way of proceeding at the Flagstaff observatory are known which constitute evidence as to the great personal significance to Lowell of his findings. One is that he made every one of the key drawings of the planet himself—and there were, over the years, upwards of ten thousand of them. Another aspect is that, finding out that the seeing of canals occurred oftener and less ambiguously when the smaller telescopes were used, Lowell used these instruments far oftener in his work than the more powerful ones, claiming that magnification of atmospheric perturbation with the larger telescopes vitiated their use for observation of the canals.

Lowell's disappointment when he first attempted to use a really large telescope is reported by his brother in an interesting passage (Lowell, 1935).

He observed without a break all summer and autumn, but aware that the atmosphere at Flagstaff was not so good in the winter, he decided to try that of Mexico, and thither he went in December taking the (new) 24-inch telescope. Before the dome therefor was built he saw well with the six-inch; but for the larger glass the results were on the whole disappointing. Yet the observations in Mexico were by no means unproductive. To his father he writes: 'In addition to all that I have told you before, Mr Douglas has just made some interesting studies of Jupiter's satellites, seeing them even better than we did at Flagstaff. ...Mercury, Venus, Mars, and Jupiter's satellites have all revealed new things about themselves....'

But his personal hopes of contributing further to science, or diffusing the knowledge learned, were destined to be sadly postponed. In the spring he left Mexico, and the telescope was returned to Flagstaff in May; but although he could stand observing day and night without sufficient sleep while stimulated by the quest, the long strain proved too much, and he came back to Boston nervously shattered.... The physicians put him to bed in his father's house in Brookline....

Discoveries about the satellites of Jupiter were no adequate consolation for not being able to see the canals of Mars. Lowell never used Mexico as an observation post again, and he never again relied upon the splendid 24-inch telescope for observation of Mars.

As a matter of fact, the experiences in Mexico were a severe emotional shock. Lowell was diagnosed as suffering from neurasthenia. During the ensuing period, he took a number of long, leisurely trips. He rested; he visited friends; he wrote sporadically. There were long stretches of idleness. The contrast with the high level of activity of the year 1894 could not have been greater.

This is an obscure period in Lowell's life. So much so that his brother refers to it as 'illness and eclipse'. Lowell seems not to have recovered fully until the spring of 1901, when he was stimulated by an approaching opposition of Mars and returned to his observatory.

VI

There seems to be little room for doubt that Lowell's ideas about Mars were of intense and personal significance. The question as to what kind of significance it was is far more difficult to answer, but it appears that the significance was largely unconscious, and in some fashion, quite specific.

To establish the first point, two bits of evidence may suffice. First, when, in *Mars* and *Mars and its Canals*, Lowell is writing about the (conscious) significance and implications of his discoveries, his tone is altogether less excited than in passages such as those previously quoted, having to do with introductory material or with the observations themselves. Sometimes the tone even descends to that of the cliché.

The second bit of evidence derives from Lowell's preference for the smaller telescopes. Habitually working at or just beyond the resolving power of his instruments, Lowell was setting up conditions not dissimilar to those used in modern projective psychological tests, such as the Rorschach or Thematic Apperception, under which unconscious forces are given the maximum opportunity to exert effects upon perception and interpretation.

Parenthetically, it may be remarked that Lowell's failure to sustain his illusion when in Mexico, causing the development of a psychoneurosis, is also suggestive of the involvement of unconscious conflicts.

In addition, the Mexican fiasco affords evidence that the significance of the Martian discoveries was quite specific. Other discoveries, even other astronomical discoveries, could by no means serve the same function in Lowell's psychological economy.

Another point of evidence for the specificity of the unconscious fantasies connected with Lowell's ideas of Mars lies in the description in the book *Mars*—excluded from the more carefully written *Mars and its Canals*—of what Martians may be like. In this description one is asked to suppose the Martians 'to be constructed three times as large as a human being in every dimension'. A highly specific detail of this sort, not logically required by the rest of the argument, strongly suggests that the unconscious meaning of Lowell's ideas about Mars were specific.

If one puts together the several features of the Martians which are mentioned in Lowell's writings, one obtains the following picture: the Martians are older than we (of an older race), wiser and more puissant (their greater works), and physically larger. The total impression received is well-nigh unmistakable: it is the child's picture of parents. It seems likely by long odds that Lowell's unconscious fantasies had to do with parent-figures.

Before attempting to go further with an exploration of the unconscious significance of Mars and the Martians in Lowell's mind, it is of importance to pause to review some of the features of Lowell's personality. Only in this way can one judge if further speculation about this aspect of his life is consistent with what is known about the man himself.

VII

Perhaps the foremost personal quality of Lowell was his brilliance. James Russell Lowell, a distant cousin, referred to him as the most brilliant young man in Boston. The statement received corroboration from other sources. Lafcadio Hearn, author and literary critic, wrote: 'If I had Lowell's genius...how happy I should be....I am heavily handicapped in competing with writers as much below Lowell as he is above me.'

Lowell was a person of very wide interests. Among the really serious ones were astronomy, mathematics, languages, literature, travel and anthropology. But he was also interested in botany, horticulture, natural history and photography. He played tennis and polo, at one time owning the fastest polo pony in the United States.

Judging by existing accounts and photographs, the household in which Lowell was raised was at once sheltered and stimulating. The family was wealthy and the children were shielded from many outside influences. On the other hand, the intellectual stimulation was intense, and, being thrown much together, the members of the family seem to have reacted intensely to one another. Judging merely from the life and writings of Lowell's sister, the famous poetess, Amy, one would be inclined to say that the atmosphere of this home was unusual. The emotional inhibitions and the exhibitionism of the cigar-smoking Amy must have had their explanations.

That Lowell was given to handling emotional disappointments through intellectual defences is indicated in an anecdote which has been preserved of his childhood. When, as a young boy, Lowell had the experience of seeing a paper boat he was sailing wreck itself and sink, he went immediately into the house and eased his feelings by writing a poem of a hundred lines in Latin.

Lowell's relationships to his parents can be clearly glimpsed. His enthusiastic, affectionate nature and his exceptionally intense attachment to his mother are suggested in the following passage from a letter written when he was ten. 'For Papa, Lawrence, and Katie, *1,000 basiers chacun, et gardez 10,000 pour vous meme.*' Lowell kept in very close touch with his mother throughout her life, writing to her

proudly of his discoveries, some of which must have been quite beyond her ken.

Although their surface relations were correct, there seems no question but that Lowell feared his father. It was under the latter's influence that he entered the family business upon graduation from college, managing trust funds and serving as treasurer to a textile firm. The problem of asserting himself must have been severe, for it is difficult to imagine enterprises less gratifying to a young man of Lowell's temperament. Indeed, it was six years until he could free himself, which he did by means of his first visit to Japan.

His uneasiness toward his father persisted and, a bit later, is specifically referred to by Sturgis Bigelow. Because of his rapid assimilation of Far Eastern culture, Lowell was offered the position of General Counsellor to the embassy being sent from Korea to the United States. In discussing the uncomfortable doubt into which Lowell was plunged by this offer, Bigelow wrote that his hesitation was mainly due to anxiety as to what his father would say, adding: 'He distrusts himself too much; he has great ability...and he only needs to be assured that he is doing the right thing to make a success (of it).' Lowell was at this time 28 years of age.

Lowell's relationship to women is of considerable interest. Most conspicuous is the fact that, highly eligible by reasons of birth, breeding, and economic position, he remained a bachelor until the age of 53. (At which time he married Miss Constance Keith, his next-door neighbour in Boston.) As is not uncommon in a man with rather severe conflicts about women, Lowell seems to have both idealized and depreciated them. As an example of the restraint and idealization, there are comments such as those of a deeply admiring maiden lady (Leonard, 1921), an employee of the observatory: 'He was a wit....His dinner stories were *sans pareil*; *sans reproches*.' As an example of the depreciation, there are Lowell's comments about a Geisha who was assigned to his entertainment on one of his visits to Tokyo. '(The girl), who was too lazy to move, amused herself by asking (me) to secure for her some cockle shells which attracted her infantile mind. Her childish delight, surprise, and ignorant cruelty to these crustacea were a striking index of the geisha mind.'

The quotation just cited is from a series of letters to F. J. Stimson, a friend back home. These letters throw much light on Lowell's inhibitions regarding women. At one point he refers to his 'well-known antipathy to the sex'. He records his encounters with various Geisha in a style which is different from his usual effective way of writing, seeming to cloak embarrassment with a self-conscious humour.

I had taken my camera along with me, having the wisteria in mind but with no ulterior object.... There she was, and her image instantly suggested to my mind the advisability of making her immortal....Flirtation's photograph or photographic flirtation; alliteration artful aid again. C says he shouldn't think one's head under a black cloth would be exactly the attitude for the affair. But this only shows how no device however humble should ever be scorned. She stoops to conquer, why may not he....There the deed was done. I discovered subsequently that she was a virgin— to photography. It is confidently reported that the other kind existeth not in the island.

In the same letter, Lowell goes on in a curious passage to describe his development of the photographic negative. Again the impression is given of wit being used to handle the thrust of disturbing impulses—in this instance of a voyeuristic nature.

I imagine to your dull eye of faith, the laboratory dark as Erebus, black as the crime perpetuated therein, save for the lurid glare of the patent lamp that threw its crimson dye of guilt upon the deed; the lovely image growing into life. In her bath too—of phyrogallic acid. Our friend Pygmalion worked in the day. Such indecent exposure would have killed my little girl. She would have faded away for very shame. Our *premieres delices* were passed before brutalizing man or even possibly objectionable nature had anything to say in the matter.

Would it be indecent to add that I left her washing in her tub. Scientifically, I had accomplished that most difficult of results, the establishment of a negative.

In a passage of Miss Leonard's book, there is again evidence of a voyeuristic orientation. Having arisen early to go to the observatory, Lowell is quoted as having said of seeing the dawn: 'I have been so overcome by her roseate blush of surprised confusion that I feel like an impertinent intruder who would better have waited until expected by the Sun.'

In an attempt to arrive at a formulation of a personality or of a given symptom-picture, leads are often afforded by minor features—habits, mannerisms, eccentricities. One such feature appears to be the matter of Lowell's always being in a hurry. As Miss Leonard wrote: 'In suggesting that anything be done, even a trivial matter, he always added, "at once!"' One receives the clear impression that his great capacity for work was not matched by Lowell by an equal or even a normal capacity for sustaining tension. It is as if Lowell felt that if action did not immediately follow the thought, something might interfere.

How may one summarize and organize the above material in a way which is relevant to the present inquiry? One may start by emphasizing Lowell's quite exceptional intellectual endowment. This feature is so marked that one should be perfectly safe in saying that whatever inner conflicts such an individual might have would be likely to be handled through the use of intellectual resources in so far as possible and would be likely to be given a highly individual type of solution.

As to the nature of the unconscious conflicts, one may say with some assurance that, whatever else may have been present, unresolved oedipal problems were surely of great significance. A number of elements, including the continuing anxiety toward the father and the sexual inhibition, suggest that unconscious castration fear was an important component in the unresolved conflicts. Renunciation of an adult heterosexual adjustment was one

defensive measure. Highly refined voyeuristic tendencies were present. Through these, some libidinal gratification could be obtained and some reassurance sought. A consideration of this line of development assumes particular interest in the present inquiry, which has taken as its starting-point the subject's preoccupation with what he had 'seen'.

VIII

The classical formulation of voyeurism, it will be recalled, gives it a dual function (Fenichel, 1945):

The childhood experiences on which voyeurs are fixated sometimes are scenes that gave reassurance—for example, such scenes as the incident in the case of Freud's foot fetishist. More frequently, voyeurs are fixated on experiences that aroused their castration anxiety, either primal scenes or the sight of adult genitals. The patient attempts to deny the justification of his fright by repeating the frightening scenes with certain alterations; this type of voyeurism is based on the hunger for screen experiences, that is, for experiences sufficiently like the original to be substituted for it, but differing in the essential point and thereby giving reassurance that there is no danger. This tendency may be condensed with a tendency to repeat a traumatic scene for the purpose of seeking a belated mastery.

Seeking reassurance that there is no danger (of castration) and seeking belated mastery over a traumatic experience: these are, as a rule, the ego values of the phenomenon of voyeurism, which ordinarily are combined with some element of libidinal satisfaction. Like the other sexual deviations, voyeurism is, of course, capable of many degrees of removal, through the mechanisms of displacement and substitution, from the field of direct expression to that of symbolic expression.

It is perfectly clear that, if voyeuristic tendencies were of real significance in Lowell's life, the voyeurism was of a highly symbolic variety. Nothing would have been further removed from Lowell's fastidious and refined

temperament than undisguised indulgence in perverse activity. Granting this, how close do the ideas about Mars come to representing the elements of an unconscious, symbolic voyeuristic experience?

Consider the two principal components in the ideas about Mars, the one having to do entirely with what was 'seen', the other having to do both with what was 'seen' and with what was immediately inferred. (1) *Something incomplete was perceived as something complete.* A series of roughly linear streaks and patches was seen as a series of perfect lines. (2) The visualization which followed, partly a sensory and partly an imaginary experience, was of *a precious fluid being pumped through tubes, making the planet fertile.* Water from the polar caps was visualized as being forced through the canals and causing the wave of darkening, considered to be vegetation springing to life.

Taken thus simply, the ideas speak for themselves. It can scarcely be doubted what they are saying in the language of the unconscious: they are a denial of castration and a (projected) representation of the process of procreation, highly intellectualized and idealized. When one adds to this the implications of Lowell's visualization of the Martians as parent figures, it seems wholly likely that the unconscious fantasies refer back to disturbing childhood impressions.

IX

Is there a means of validating the above suppositions? Only an indirect one—and thus, if one is to avoid Lowell's error one must be resigned to considering them only as suppositions. The indirect means is to note the positions. The indirect means is to note the relationship between Lowell's astronomical activities and the pattern of his life. The bald sequence of events, stripped of interpretations, is as follows: learning of Schiaparelli's work, pondering it, deciding to continue this work and reach a basis for conclusions, spending a very active year at Flagstaff achieving a position of confident high spirits, taking the trip to Mexico and learning that observations made

with the powerful new telescope did not agree with those made at Flagstaff with the smaller telescope, some sort of nervous collapse, a period of 'neurasthenia' with a very slow convalescence during which no work of consequence was accomplished, recovery as the opportunity presented itself for a new series of observations, making these observations with the techniques which had originally proven effective, writing the book, *Mars and its Canals*, winning a limited professional and a widespread popular approval of his ideas, marrying.

Two sequences seem particularly striking: (*a*) failure in Mexico and the period of neurasthenia; and (*b*) defending his ideas with some success and undertaking courtship and marriage. What is suggested is that the voyeuristic fantasies played a critical part in Lowell's adjustment. If they were shattered, Lowell's inner conflicts drew to themselves so much energy as to prevent the subject from carrying on a productive life. If, on the other hand, they could be sustained, they were of real adjustment value, allowing Lowell to behave as a relatively mature adult male.

Two final biographical points may be noted here, consonant with the speculations just offered. The first has to do with the beginning of Lowell's interest in observational astronomy. If the thesis of this paper is somewhere near the truth, one would expect that this interest would have begun at a time of libidinal stirring, serving to absorb sexual curiosity and afford some sort of reassurance. This was, indeed, the case. Greenslet reports: 'At thirteen he became a watcher of the skies through a $2\frac{1}{4}$-inch telescope installed in the cupola that crowned the family mansion.' Lowell's brother, Abbott Lawrence, adds: '... later in life he recalled that with it he had seen the white snow cap on the pole of Mars crowning a globe spread with blue-green patches on an orange ground.' In other words, Lowell's interest in astronomy, and specifically in Mars, coincided in onset with puberty.

The second point has to do with the connexion between the Martian fantasies and the

subject's performance in real life. Illustrations are to be found in several of Lowell's letters. The following quotation, taken from a letter written to Miss Leonard from Washington, is typical and shows the extent to which Lowell identified with the creatures of his imagination. 'Saw the Senate this morning, and believe I listened to a poor showing of oratory. We Martians can do better.'

SUMMARY

The thesis of the present paper is that Lowell's energetic investigations of Mars, a certain proportion of his 'findings', and a large proportion of his conclusions were heavily influenced by unconscious forces, taking the final form of incompletely sublimated voyeuristic impulses. These impulses were a product of Lowell's unresolved oedipal conflicts.

REFERENCES

FENICHEL, O. (1945). *The Psychoanalytic Theory of Neurosis.* New York: Norton.

LEONARD, L. (1921). *Percival Lowell: an Afterglow.* Boston: Badger.

LOWELL, A. L. (1935). *Biography of Percival Lowell.* New York: Macmillan.

MOORE, P. (1954). *A Guide to the Planets.* New York: Norton.

Choices of marriage partners by men coming from monosexual sibling configurations

By WALTER TOMAN*

INTRODUCTION

The author has presented reasons and empirical evidence before (Toman, 1959*a–c*, 1960*a–c*, 1962, *a, b*, 1963; Toman & Gray, 1961), that certain simple and easily established data about family constellations do characterize persons in a number of important areas of life and do tend to co-determine in a traceable and statistically predictable way their longer-term interpersonal relationships whether they involve authority figures, peers or dependants and children. Data about the ages (age-ranks) and sexes of siblings, about the ages (age-ranks) and sexes of the parents' siblings, and about losses of parents or siblings suffered by the person in question or his/her parents have proven to be discriminating among individuals and groups of individuals. While a few other simple data such as geographic stability of home, incidents of illness, hospitalization, travels, etc. (amounting to temporary losses of family members) proved discriminatory also, they shall be ignored in this context. The data mentioned of a person's and his parents' sibling configurations, on the other hand, were found also to have explanatory power on the basis of a theorem into which the author has tried to condense a multitude of correlative trends that he has observed in his studies: extra-familial interpersonal relationships have a better chance of happiness and lasting success, other things being equal, the closer they duplicate early intra-familial interpersonal relationships.

This would mean that, for example, older brothers of sisters tend to be married best to youngest sisters of brothers. They duplicate

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for each other by seniority-juniority and by sex a peer relationship they have had at home. The same would hold of youngest brothers of sisters when married to oldest sisters of brothers. Poorer prospects would prevail for oldest brothers of brothers married to oldest sisters of sisters. They would have a rank- and sex-conflict. Neither is used to living with a peer of the opposite sex and both would try to dominate the other. The same would hold for marriages between youngest brothers of brothers and youngest sisters of sisters, except that both would try forever to find leadership in the other. The chances for partners to a relationship who come from larger and more complicated sibling configurations (who have, for example, both brothers and sisters, older and younger siblings) tend to be better, other things being equal, if they duplicate for one another at least one of their sibling relationships.

This rule would hold equally for losses. Their most general psychological consequence is an expectation that they can happen again. Under certain conditions this expectation may operate like a wish. In either case the net effect for the person would be a more or less diminished freedom in the appraisal and selection of opportunities for longer-range interpersonal relationship as well as in actual choices made. Not infrequently a person who is bound to disappear again is chosen in the first place.

The most decisive among a number of systematic tests of the duplication-theorem was the comparison of 'happily married' and divorced couples. In all of the author's studies as well as in this one, happiness and success of an interpersonal relationship was defined by simple true-to-life criteria rather than by those established via psychological 'instruments',

such as tests. In this case 'happy marriage' meant married for at least ten years and being parents of at least two children. It was found that monosexual sibling configurations and rank-conflicts predominated in number among the divorced partners, whereas a majority of 'happily married' partners were well-matched by criteria outlined. More often than chance older brothers of sisters had married younger sisters of brothers, and younger brothers of sisters older sisters of brothers. Losses suffered by partners or the parents were significantly more frequent among the divorcees (Toman, 1962*b*).

It has never been the author's contention that parents matter less than siblings, psychologically. The parents' characters and interpersonal proclivities, however, have been found to be co-determined by their own sibling configurations, including losses. The parents may be in various degrees of harmony with one another by the criteria mentioned. The greater his parent's harmony, the more likely is it for a given person that he can experience freely and enjoy all contacts with his siblings. The greater the conflict that prevails among the parents and/or the greater the losses they have suffered themselves, the greater the probability that the person in question (and his siblings) stay affected by that conflict. They have to keep a watchful eye on their parents rather than enjoy each other.

On the basis of their own sibling positions, a person's parents may also be in various degrees of harmony or conflict with him (her). Failing to consider that part or aspect of family configurations may be partly responsible for the occasional relative failures of previous psychological studies of sibling position to establish clear trends (e.g. Goodenough & Leahy, 1927; Guilford & Worcester, 1930; Wile & Jones, 1937; Sears, 1950; Koch, 1956).

PRESENT STUDY

The present study concerns males coming from monosexual sibling configurations or, more specifically, oldest brothers of brothers and youngest brothers of brothers. Having no sisters for peers those men are theoretically expected to choose as best they can at least by rank. Oldest brothers would tend to choose younger sisters for wives and youngest brothers would tend to choose older sisters. However, the men's mothers having been the only females in their original families (from whom they would at least start learning how to deal with women), those mothers may also tend to affect the men's choices. If they do, the oldest brothers of brothers should be more amenable to such an influence than the youngest brothers of brothers. Oldest siblings are the first to wise up to their parents, their characters and their relationship to each other. They are the pace-setters, and if conflict prevails among the parents or if the parents have suffered losses in their early lives, the oldest siblings tend to get the brunt of it. They serve as buffers for their younger siblings.

Twenty oldest and twenty youngest brothers of brothers only, all of them married, their ages ranging from 23 to 54 years at the time of the investigation and having 1·8 and 2·0 children respectively on average were explored for sibling positions of their wives considering only age-ranks. Table 1 shows the distribution.

Apparently oldest and youngest brothers of brothers chose their partners for significantly different aspects. Chi-square tests for first two columns only were significant on the 5% level. Oldest brothers of brothers tend to choose youngest sisters, and youngest brothers of brothers tend to choose oldest sisters, more frequently than chance.

Investigating the 'wrong' choices of the oldest brothers further, i.e. those five cases where oldest brothers had chosen oldest sisters for wives, it was found that those oldest brothers' *mothers* had been oldest sisters themselves in four of those five cases. Doing the same for the 'wrong' choices of the youngest brothers, the two cases where they had chosen youngest sisters for wives, it was found that the *mothers* of both men had been youngest sisters themselves. In other words, in six of the seven 'wrong' choices of wives by

Table 1. *Distribution of wives of oldest and youngest brothers of brothers according to wives' sibling positions*

	Wives			
Husbands	Oldest sisters	Youngest sisters	Middle sisters	Singletons
Youngest brothers of brothers	9	2	7	2
Oldest brothers of brothers	5	7	4	4

men coming from monosexual sibling configurations their wives had similar sibling positions as the men's mothers. This corresponds to only three such coincidences in those nine cases where youngest brothers chose oldest sisters and to another three such coincidences in those seven cases where oldest brothers chose youngest sisters.

Hence it could be argued that the men coming from monosexual sibling configurations chose a spouse after the image of their mother when other considerations, unconscious ones, to be sure, were not made or did not work out. It might also be said that their mothers prevented those men from choosing according to other considerations, and that they seemed to have a greater influence on their oldest sons than on their youngest. While these aspects are being studied with other samples, the present data are insufficient for further comment.

It has been argued before (Toman, 1959a, b, 1960b, 1962a) that singletons, having no sibling position of their own, tend to adopt to some extent the sibling position of their same-sex parent. In the present sample the two singletons married by youngest brothers of brothers (see Table 1) turned out to be the daughters of one oldest sister and one middle sister (to be exact, the second oldest of five siblings and the oldest girl), whereas the four singletons married by oldest brothers of brothers were the daughters of three youngest sisters and one oldest sister. This appears to confirm the trend of complementarity by sibling rank among marriage partners.

DISCUSSION

The study presented is only a small aspect in a larger project that the author has been engaged in for many years and that has recently been sponsored by Deutsche Forschungsgemeinschaft. Men, rather than women, coming from monosexual sibling configurations were chosen since previous work, also with friendships formed on college level, seemed to suggest that women, being the ones generally to be chosen rather than those to choose, tended to reflect the trend for rank-complementarity less clearly by themselves. A somewhat similar difference between men and women was observed in the study of 'happy marriages' and divorces (Toman, 1962b). Among the divorced partners women had suffered significantly more losses than men. Losses, apparently, did not prevent them from being chosen, but might have, had they been in men's positions, i.e. having to do the choosing.

The author hopes that this study will further the interest in this field which he has come to consider a gold mine for probing into the psychology of life, so to speak, and for research. The predominance of older sisters among student nurses, of senior siblings among teaching fellows or, e.g. volunteers for certain psychological experiments, or a little fact such as that, in the author's own course on 'advanced child psychology', student enrolment showed a strong predominance of oldest siblings (significant on the 1 % level), are a few of many incidents where data of family constellations play a traceable part. Perhaps the most

striking evidence (at that time, summer 1958, still surprising to the suthor) was found in a study of women who had chosen to work as 'mothers' in children's villages (a central European institution gathering children from broken homes in groups of nine children of different ages and both sexes and giving them houses and 'mothers'). Those women had not only all suffered losses themselves, but came from families of a size of nine children, on average, in which there prevailed a shortage of men. Females outnumbered males by about 2:1, the same ratio by which female adults tended to outnumber male adults in the children's villages. For some reason, however, their charges, the children, were about twice as many boys as girls (Toman, 1959a, b).

SUMMARY

The choices of wives by oldest and by youngest brothers of brothers only were found to be significantly different according to the wives' sibling positions. Oldest brothers of brothers tended to choose youngest sisters, and youngest brothers of brothers oldest sisters, more often than chance. The sibling positions of the men's mothers seemed also to influence their son's choices of wives.

REFERENCES

GOODENOUGH, F. C. & LEAHY, A. M. (1927). The effect of certain family relationships upon the development of personality. *Ped. Sem.* 34, 45–71.

GUILFORD, R. B. & WORCESTER, D. A. (1930). A comparative study of the only and non-only child. *J. Genet. Psychol.* 38, 411–26.

KOCH, H. L. (1956). Children's attitudes toward their peers as related to certain characteristics of their siblings. *Psychol. Monogr.* 70 (19), no. 426.

SEARS, R. R. (1950). Ordinal position in the family as a psychological variable. *Amer. Sociol. Rev.* 15, 397–401.

TOMAN, W. (1959a). Die Familienkonstellation und ihre psychologische Bedeutung. *Psychol. Rundschau*, 10, 1–15.

TOMAN, W. (1959b). Family constellation as a basic personality determinant. *J. Indiv. Psychol.* 15, 199–211.

TOMAN, W. (1959c). Family constellation as a character and marriage determinant. *Int. J. Psychoanal.* 40, 316–19.

TOMAN, W. (1960a). On the periodicity of motivation. In *Nebraska Symposium on Motivation,* pp. 80–95. Ed. M. R. Jones. Lincoln: University of Nebraska Press.

TOMAN, W. (1960b). Haupttypen der Familienkonstellation. *Psychol. Rundschau,* 11, 273–84.

TOMAN, W. (1960c). *Introduction to Psychoanalytic Theory of Motivation.* London, New York: Pergamon Press.

TOMAN, W. (1962a). *Family Constellation: Theory and Practice of a Psychological Game.* New York: Springer.

TOMAN, W. (1962b). Family constellation of the partners of divorced and married couples. *J. Indiv. Psychol.* 18, 48–51.

TOMAN, W. (1963). Family constellations of marriage partners with large chronological age-differences. *Psychol. Rep.* (submitted for publication).

TOMAN, W. & GRAY, B. (1961). Family constellations of 'normal' and 'disturbed' marriages: an empirical study. *J. Indiv. Psychol.* 17, 93–5.

WILE, I. S. & JONES, A. B. (1937). Ordinal position and the behavior disorders of young children. *J. Genet. Psychol.* 51, 61–93.

Anxiety in pregnancy

By L. B. BROWN*

The psychoanalysts' long-standing interest in the psychological features of pregnancy has over recent years been supplemented by some empirical studies in which comparisons have been made between variously defined criterion groups. A survey of these studies reveals differences in the criteria used to define groups, the manner of approaching the problem and the stage in pregnancy at which the data have been collected. Despite these differences the findings show some consistencies. In defining the groups for study and comparison, the criteria used have been either psychological or based on a medical diagnosis. Other studies have been concerned with psychiatric breakdown in pregnancy, but this is a problem outside the present inquiry.

Rosengren (1961*b*), using the notion of a tendency to adopt a sick role, as well as measures of social aspirations, social status and social mobility, concludes that his study 'offers support for the proposition that social and personal disturbances or instability are important sources for motivations toward the role of the sick—particularly with regard to the ambivalent organic condition of pregnancy'. Coppen (1958, 1959), Cramond (1954), Dalton (1960), Hetzel, Breuer & Poidevin (1961), and Winokur & Werboff (1956) used in their studies some diagnostic criterion, usually pre-eclamptic toxaemia, hyperemesis gravidarum and either the length of labour (but not as a continuous variable) or a 'long' (but not as a continuous variable) or a 'long' labour (defined by Hetzel *et al.* as 'continuous labour for more than 24 hours'), or some other definition of 'abnormality'. They all find some relationships between psychological factors and their diagnostic criteria. Davids, de Vault & Talmadge (1961*a*, *b*), in defining an abnormal labour group, used delivery room records to which the psychological data were related 'blind', finding that the abnormal group had a higher mean manifest anxiety score than the normal group.

These pregnancy studies have gathered their data at different times—either early in pregnancy (Dalton, 1960), late in pregnancy (Winokur & Werboff, 1956; Davids *et al.* 1961*a*, *b*; Rosengren, 1961*a*), or immediately post-natally (Coppen, 1958; Cramond, 1954; Hetzel *et al.* 1961). Davids interviewed his subjects antenatally, and then followed them up 6 weeks after delivery at a post-natal clinic. Clearly, the stage in pregnancy at which data are collected will influence the results of any investigation, although the purpose of the study will determine the stage at which the subjects will be most suitably assessed.

A further difference between the studies is the method used in deriving the psychological concomitants of the pregnancy. Interview results have been handled objectively, or assessed for evidence of 'stress' (Hetzel *et al.* 1961), conventional inventories and other psychological tests have been used, including Manifest Anxiety (Davids *et al.* 1961*a*, *b*), Neuroticism (Coppen, 1958), Thematic Apperception Test and Sentence Completion (Davids), M.M.P.I. Lie Score (Cramond, 1954) and *ad hoc* questionnaires (Winokur & Werboff, 1956).

Despite these differences between the studies, there is general agreement that some relationship exists between the course of pregnancy and psychological factors, although there is little congruity about specific results. However, all investigators emphasize that their findings warrant further investigation, while it is obvious that pregnancy is an intrinsically important, if somewhat neglected, period of psychological interest.

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Anxiety is the most general concept that has been used to describe the psychological condition of an 'abnormal' pregnancy. An alternative concept has been 'stress', but the difficulties of defining it operationally are well recognized. It is also asserted that certain abnormal groups have abnormal personality characteristics (the 'dysfunction temperament' described by Cramond, 1954) or atypical social experiences as either a causal, or at least a concomitant, factor.

A study of anxiety in pregnancy can contribute to an understanding of the psychological changes associated with pregnancy, and it can also be related to the general hypothesis of a psychosomatic aetiology of some disease states. The psychosomatic hypothesis has been applied particularly in pregnancy, and it is here that the hypothesis can be tested under ideal conditions because of the ready availability of a control group whose pregnancies are 'normal' to compare with the variously defined abnormal groups. It would seem essential, however, that any study of the effect of anxiety on the course of pregnancy must use data collected at the time and not retrospectively, when problems of the puerperium are significant. In Davids's study, the retested abnormal group still had a higher manifest anxiety score than the normal group 6 weeks after delivery, although the difference was not statistically significant, while the difference in scores between these two groups was significant during pregnancy. Hetzel et al. (1961) conclude from their retrospective study that 'a significantly higher incidence of stressful life situations was found in the complicated pregnancies', and Davids et al. (1961 a, b) conclude that: 'It seems likely that women who are alienated are in a state of personal and social maladjustment and, consequently, are habitually in a state of greater emotional stress. If this is in fact the case, then the present findings lend support to the notion that there is an association between a stressful or psychologically disturbed pregnancy and the tendency to experience delivery room complications and to give birth to children who suffer from various forms of physical complications.'

From the previous work, it would be expected that relationships will be found between psychological variables and the course of pregnancy, as established by a medical diagnosis, although it is clearly necessary to allow for the subjects' parity. During pregnancy there might also be significant relationships between the psychological variables themselves. The psychological variables found from previous studies to be of most likely relevance are measures of anxiety (manifest anxiety and neuroticism) and the M.M.P.I. lie score. The present paper is primarily concerned with the results from these and four other measures—bodily symptoms in pregnancy, specific pregnancy anxieties, husband's household participation, and wife's reported difference from her husband. These measures were obtained after an extensive interview, which was conducted during the last trimester of the subjects' first pregnancy. The results from the interview are to be reported separately (Brown, 1964). Subsequently an obstetrician (Dr L. O. S. Poidevin) established diagnoses of the length of time in continuous labour and if either mild, moderate or severe pre-eclamptic toxaemia developed, using the criteria set down by Poidevin (1960). These limited diagnoses disregard potentially significant material, such as the presence of other abnormalities during birth, but the opinion was offered that the incidence of such abnormalities is unstable, being dependent to some extent on the people in attendance, which varies not only from one labour to another, but from time to time for the same person who has a long labour.

As women obviously differ in the number of symptoms they present in pregnancy, and Dalton (1960) offers evidence to suggest that the course of pregnancy is different for those with two or more symptoms from its course in those with less than two symptoms, a system of classification based on symptoms also seemed a meaningful one. Hetzel et al. (1961) found that all their abnormal groups had a higher incidence of symptoms in pregnancy and that

the prolonged labour and toxaemia groups had more emotional symptoms (pregnancy worries?). It has been assumed here that, when presented with a check-list of relevant bodily symptoms, a woman who sees her pregnancy as a time of 'sickness' will find more symptoms that apply to her, than would a woman who was not expecting to find herself 'sick'. Thus the number of symptoms marked can be thought of as related to a 'tendency to adopt the sick role'. The argument supporting this assumption is similar to that of Mechanic & Volkart (1961) although they used different questions to assess this tendency.

Specifically, the following hypotheses were tested:

(1) That there is a relationship between anxiety, and length of time in labour and the incidence of pre-eclamptic toxaemia.

(2) That the more bodily symptoms are reported in pregnancy, the greater will be the anxiety level.

(3) That those vomiting in pregnancy will be more anxious than non-vomiters.

(4) That other psychological characteristics, such as extraversion and M.M.P.I. lie score, will not be related to symptomatology or diagnosis.

The recent literature on anxiety is voluminous and no attempt is made to survey it here as Sarason (1960) and Martin (1961) cover most that is relevant.

METHOD

The subjects

The subjects were women presenting themselves at the two Adelaide hospitals providing public obstetric services, from which a series of primigravidae were interviewed in the ante-natal clinic when they were 30 weeks or more pregnant, as estimated by abdominal palpation in the routine examination. No one was interviewed on her first visit to the clinic, and all were married, or separated, when seen, and born in either Australia, New Zealand or Great Britain. At the Queen Elizabeth Hospital, thirty-eight people were interviewed during the

latter part of 1959, and these results have been treated as pilot data and are not reported. The main study was conducted during 1960 at the Queen Victoria Maternity Hospital, with 148 people. During the period of the study, all who satisfied the criteria for inclusion were seen.

Procedure

The nurse-in-charge of the ante-natal clinic approached those women who satisfied the criteria, to ensure their co-operation, and they were then introduced to the psychologist, who began the interview immediately.

Subjects were seen separately in a small room, and the procedure of investigation began with a structured interview which covered a wide range, and was followed by two check-lists, the personality inventories, and the rating scales. When filling in the check-lists, no help was given, but in the inventories each item was read while the subject herself followed and then she marked 'true' or 'false' as appropriate. This procedure was used in order to control for differences in ability to understand the items and also to ensure that a roughly similar amount of time was spent on the task by each subject.

Measures

Two check-lists were specially constructed for this study. The first contained 'twenty things that worry people during pregnancy'. The instruction was to 'tick those things that worry you during your pregnancy. Add at the end anything else that has worried you.' The list began with 'trouble about money' and concluded with 'that you might not know how to look after the baby'. This check-list allows an assessment of anxiety specific to pregnancy. The second check-list contained 'nineteen bodily complaints that have been found to happen in people who are pregnant. Tick those that you have noticed particularly about yourself. At the end add anything else that you have noticed about yourself.' This list began with 'feeling of sickness' and finished with 'varicose veins'. The score for each check-list

was the number of items marked. Reliability was assessed by readministering the check-lists, to a sample of twenty, one week after the first administration. There was 92% agreement between all markings on the two administrations, and a correlation of 0·80 between scores for each of the administrations.

Although there is no direct evidence of validity, a number of obvious results (such as correlation of −0·35 between school-leaving age and family place in the P.E.T. group) lead to confidence in the findings.

The first part of the 116-item inventory was the Taylor Manifest Anxiety Scale (1953), followed by the M.M.P.I. Lie Scale items which were presented spaced randomly among the masculinity–feminity scale items from the M.M.P.I. Eysenck's (1958) shortened forms of his Neuroticism and Extraversion Inventories followed, after which there were a few miscellaneous items concerned with the pregnancy itself. The husband's participation in household duties was assessed by presenting a series of statements of household activities. For each of these the question was, 'How often does your husband help?' and the alternatives offered were 'often, sometimes, seldom, never'. A score was produced by summing weights allocated to these alternatives. The difference between the wife's self-report and her account of her husband was assessed by presenting a series of personality descriptions on which the woman was asked to rate herself first, and then she was asked to rate her husband on the same trait names. A 'difference' score was found from the summed difference between self-assessments and assessments of the husband, with alternatives again weighted arithmetically.

Criterion classifications

The sample studied was divided into criterion groups, on the basis of three variables. The first variable was the number of bodily symptoms marked in the second check-list, giving a classification in terms of a tendency to adopt the sick role. The distribution of markings was divided to give four groups, and com-

parisons have been made between the high and low groups ($N = 26$ and 37, respectively). A further subdivision was made on the basis of the first two items in this same check-list. These items were 'feeling of sickness' and 'frequent vomiting'—and those who marked neither of them ($N = 64$) have been compared with those who marked them both ($N = 35$). Ideally this division would have been made from a medical diagnosis, but as excessive vomiting seems accepted by so many women as a normal part of pregnancy, many who are in fact vomiting do not present this symptom to their doctors. For this reason the classification into 'vomiting' and 'non-vomiting' was made from the check-list markings.

Finally, those developing pre-eclamptic toxaemia ($N = 30$) were put into one group, and compared with those in the top and bottom quartiles of the distribution of labour time of the remainder of the sample ($N = 30$ in each case). For this classification of labour time, all other kinds of abnormality occurring during pregnancy and labour have been disregarded. This gives, therefore, a toxaemic group and short (up to 5·8 hours) and long (12·25 hours and longer) labour groups on the basis of a medical diagnosis made by an obstetrician from the case records. Neither of the labour groups can necessarily be regarded as 'normal'.

In addition to the comparisons between these criterion groups, those variables from both the inventory and interview parts of the study from which continuous scores could be derived (including not only the test scores, but also weeks pregnant on the first booking, length of time married, age, years for which husband has been known and number of siblings) were intercorrelated, first for the 118 who did not develop toxaemia, and then for the thirty in the toxaemic group. The intercorrelations from the non-toxaemic group have been factor analysed.

The inventory was administered to first-year women psychology students in Adelaide, as representatives of a non-pregnant group, but they are so different from the pregnant groups

in other ways that little reliance can be placed on their appropriateness as a control group.

RESULTS

The results from an analysis of the scores of tests in the inventory are presented in Table 1, and the whole inventory has been item analysed. Reference to Table 1 shows the most consistent differences between groups to be in the high and low symptom groups and the measures of anxiety, and not between the diagnostic categories and personality or psychological variables.

Bodily symptoms in pregnancy

It is only in the measures of anxiety (sum of pregnancy worries marked, manifest anxiety and neuroticism) that the high and low bodily symptom groups have significant differences—there being no differences on scores of extraversion, the lie score, husbands' participation or reported difference from husband.

For the non-toxaemic group, the only correlations that are significant beyond the 5% level between the number of bodily symptoms and other variables are with the number of worries (0·50), manifest anxiety (0·46), neuroticism (0·34), and summed difference from

Table 1. *Mean scores for high and low criterion groups, from the main variables*

	Criterion								
	Bodily symptoms			Vomiting			Diagnosis. Labour		
Variable	Low	High	t	Low	High	t	Short	Long	P.E.T.
Pregnancy worries	2·2	6·1	5·7	3·5	5·2	3·1	3·5	4·5	4·1
Manifest anxiety	11·8	23·4	5·8	15·6	18·5	N.S.	15·3	17·5	18·8
Lie score	5·3	4·4	N.S.	4·9	4·8	N.S.	4·6	5·0	4·3
Extraversion	7·8	6·6	N.S.	7·4	6·0	2·2	6·4	6·3	7·0
Neuroticism	4·7	9·3	5·2	6·8	7·9	N.S.	6·8	6·6	6·0
Participation of husband	45·6	53·1	N.S.	49·3	50·4	N.S.	51·2	48·5	51·6
Difference from husband	9·4	7·4	N.S.	14·6	15·5	N.S.	14·8	16·0	15·1

The matrix of product moment correlations between all variables from the non-toxaemic subjects is in Table 2, where again the most consistent relationships are between the anxiety scores and the number of bodily symptoms presented. Table 3 shows the correlation matrix for the toxaemic group.

When the inventory items are analysed by criterion groups, it is those items that, judging by the item frequencies in the students' control responses, present less favourable characteristics that differentiate most frequently between all high and low groups. This is, of necessity, a rather subjective conclusion, but it suggests that in subsequent investigations some control should be exercised over the variable of social desirability.

husband (0·33). The correlation with the wife's birthplace, when scored on distance from Adelaide (the high scorers having been born farther away), was just significant (0·26). The correlation between bodily symptoms and length of time in labour was +0·04 (Rosengren's (1961 *a*) correlation is +0·27), while the correlation with the amount of vomiting is 0·55, as this score was derived from the first two items in the bodily symptoms check-list. Rosengren also reports a correlation of 0·23 between the sick role and the month of the first visit while the corresponding correlation here is +0·06.

For the toxaemic group, the inter-correlations give similar results, in that the correlation between number of bodily symptoms and

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Table 2. *Matrix of correlations, for the non-toxaemic group (N = 118), corrected to two decimal places and with the decimal points omitted*

	Bodily symptoms	M.A.S.	Neuroticism	Lie score	Extraversion	Participation	Difference H.	Weeks booked	Married	Age wife	Religion	Birth wife	Birth husband	Years known	Next baby	Left school	Siblings	Family place	Vomiting	Labour time
Pregnancy worry	+50	+52	+49	−29	−11	+08	+19	−03	−03	−08	+14	+18	+08	−06	+09	−07	−28	−10	+27	−15
Bodily symptoms		+46	+34	−16	−15	+15	+33	+06	+00	+05	+04	+26	+12	−00	+08	−08	−13	−08	+55	+04
M.A.S.			+57	−26	−16	+16	+34	+02	−07	−07	+02	+08	+01	−09	+14	−09	−01	−02	+18	+01
Neuroticism				−37	−16	+14	+30	−05	−11	−09	+05	+09	+06	−15	−15	−12	+09	+01	+08	+05
Lie score					−00	−11	−19	−07	+07	+17	+06	−07	−07	+12	+07	−05	−14	+06	−05	+06
Extraversion						−08	−23	+13	+03	+14	−01	+01	−03	−07	+09	−15	−04	+03	−16	−01
Participation							+27	+15	−08	+14	−18	+09	+20	+07	+10	−05	−04	−15	+06	−12
Difference H.								+11	+05	+09	−10	+21	+17	−02	+13	+00	−09	−09	+19	−01
Weeks booked									+25	+04	−20	+09	+20	−10	+00	+01	+01	−05	+16	−12
Married										+37	+10	+14	−00	+08	+13	−04	−10	−04	−02	+24
Age wife												+14	+15	−00	+28	−05	−05	+09	+02	+19
Religion												+13	−02	−10	+11	+09	−11	+04	−03	+17
Birth wife													+37	−09	+02	+11	−01	+02	+14	+14
Birth husband														−17	−04	+13	+09	+06	+16	−09
Years known															−05	+02	+02	−05	−14	−06
Next baby																−08	−05	+04	−11	−07
Left school																	−09	+01	+04	+09
Siblings																		+18	+14	+23
Family place																			−14	+03
Vomiting																				+07

Table 3. *Matrix of correlations, for the toxaenic group ($N = 32$), corrected to two decimal places and with the decimal points omitted*

	Bodily symptoms	M.A.S.	Neuroticism	Lie score	Extraversion	Participation	Difference H.	Weeks booked	Married	Age wife	Religion	Birth wife	Birth husband	Years known	Next baby	Left school	Siblings	Family place	P.E.T. severence	Vomiting
Pregnancy worry	+55	+41	+32	−23	+15	−04	+34	−20	−12	−04	−02	−19	+08	−29	−01	−22	+04	+02	+26	+06
Bodily symptoms		+55	+41	−08	+30	−19	+29	−14	−20	+08	−19	−06	+10	−40	−04	−11	+33	+10	−15	+20
M.A.S.			+66	−22	−11	−06	+41	−13	−05	+13	−25	+16	+31	−25	+17	−06	+27	+20	+10	+03
Neuroticism				−35	−03	+02	+52	+01	−12	+12	−27	+07	+34	−43	+33	−14	+22	+19	+12	−01
Lie score					+22	+18	−55	−42	−13	+24	−05	−09	−36	+04	−20	−11	−13	+22	−12	−04
Extraversion						+20	−30	+03	+28	+05	−24	−34	−06	+01	−01	−09	−24	+01	+08	+20
Participation							−11	−09	−22	−24	−11	+01	−00	+47	+06	+02	+16	−03	+34	−05
Difference H.								+08	−33	−08	−15	+24	+36	−14	+37	+01	+27	+26	−00	+00
Weeks booked									−27	+10	+32	+15	−00	−01	+15	−42	−02	−27	+03	+16
Married										−04	+36	−16	−11	−10	−08	−43	+06	+02	+07	−11
Age wife											−06	+32	+15	−38	−04	−13	−02	+28	−45	+02
Religion												−01	−17	−01	−17	−01	−21	−14	+11	+07
Birth wife													+01	−10	+24	+03	−29	+01	−22	+14
Birth husband														+09	−01	+20	+14	+14	+49	−19
Years known															+04	+08	+06	−08	+37	−31
Next baby																+29	−04	−12	+08	+20
Left school																	−18	−35	−09	+25
Siblings																		+22	−10	−48
Family place																			−29	+32
P.E.T.																				−20

worries is 0·55 and with neuroticism it is 0·49. In addition, the correlation with the number of years for which the husband has been known is −0·40, and with the number of siblings it is −0·33. The correlation with the score for reported difference from husband just fails to be significant.

Specific pregnancy anxiety

The correlation between the total number of pregnancy worries and manifest anxiety is 0·52 and with neuroticism it is 0·49, while with vomiting it is 0·27, for the non-toxaemic group. For the toxaemic group, these correlations are 0·41, 0·32 and 0·06, respectively. In the non-toxaemic group, the correlation with the number of siblings in the subjects' families of orientation is −0·28, and with the lie score it is −0·29, while with the length of time in labour it is +0·15, which is not statistically significant.

When the pregnancy worries were compared for the high and low bodily symptom groups, items relating directly to the husband showed greatest differences (e.g. 'quarrels with husband', 'difficulties with sex relations' and 'that your husband might lose his job') with items relating to the baby next in order of differences (e.g. 'that the baby might die', 'whether the baby would be defective'). Items relating to the woman herself (e.g. 'that your health seems different', and 'the discomfort of labour') did not give significant differences between these high and low groups.

Correlates of nausea and vomiting

Because of the understandably high correlation between the reported presence of nausea and vomiting and the total number of bodily symptoms (0·55 in the non-toxaemic group, but only 0·20 in the toxaemic group) the variables that showed significant mean differences between the vomiters and non-vomiters are the number of bodily symptoms ($t = 7\cdot4$), pregnancy worries ($t = 3\cdot1$), and extraversion ($t = 3\cdot1$), in which non-vomiters have a lower mean score. Coppen (1959)

found no difference between his vomiting and non-vomiting groups.

In the non-toxaemic group, the presence of vomiting has a correlation of 0·27 with pregnancy worries, while in the toxaemic group its only significant correlation is with the number of siblings (−0·48).

When the vomiters and non-vomiters are compared over inventory items, significant differences occur in the items showing interpersonal difficulty, and in those items which show more frequent sweating and crying among the vomiters.

The course of pregnancy

When the long and short labour groups and the toxaemic group are compared over the personality variables, there are no significant differences. These results do not support Coppen (1958), who found his toxaemic group to have a higher neuroticism score, while Davids et al. (1961b) found a significantly higher manifest anxiety score for their abnormal labour group, using a wider set of criteria. There is also no confirmation for Hetzel's (1961) finding of a higher incidence of bodily symptoms prior to pregnancy among his 'complicated' group.

In the non-toxaemic group, the only significant correlations with length of labour are the length of time married (+0·24) and the number of siblings (−0·23), and each of these is only just significant at the 0·05 level. The Lie Score has a correlation of +0·06, giving no support for Cramond's (1954) 'dysfunction temperament'.

In the toxaemic group, there are significant correlations between the severity of toxaemia and husband's participation (0·34), with the birthplace of husband (scored again in terms of distance from Adelaide) (0·49) and with the number of years for which the husband has been known (0·37). The toxaemic group appears to show greater social disturbance than the non-toxaemic group because of the greater number of significant correlations with such variables as years for which the husband has been known, and the length of time married.

In the item analysis, the main differences between the toxaemic group, and the long and short labour groups occur in items showing direct expressions of worry, including the items, 'I am the kind of person who takes things hard', 'I become nervous if I have to wait', 'I frequently find myself worrying about something' on all of which the toxaemic group has significantly more who agree. It is of interest that the student control group shows fewer differences in item frequency from the long labour group than from the short labour group.

Factor analysis

The matrix of inter-correlations for the non-toxaemic group was factor analysed on an IBM 7090 computer, using the method of principal components with a quartimax rotation. The first factor accounts for 22% of the variance and is clearly an anxiety factor, with the following rotated loadings after nineteen iterations:

Neuroticism	0·836
Manifest anxiety	0·785
Pregnancy worries	0·692
Bodily worries	0·423
Difference from H.	0·385
Years known husband	−0·261
Extraversion	−0·116
Age of woman	−0·164
Time in labour	−0·007
Vomiting	+0·076

The second factor is a labour time factor, with labour time loading 0·934 after rotation. The other largest loadings are −0·317 for number of siblings in family of orientation and +0·255 for school-leaving age, with the wife's birthplace having a loading of 0·200. The loadings of the personality variables on this factor are all around zero.

The third factor is a wife's age factor, the fourth a birthplace factor and the fifth a 'weeks to booking' factor (rotated loading 0·609) on which the loading of extraversion is 0·645. The next factor has highest loadings on the two scores that related to the husband, while the last factor is a vomiting factor (rotated loading 0·779) on which the other

highest loadings are 0·381 for the week pregnant when seen, 0·336 for pregnancy worries, and 0·737 for bodily symptoms.

DISCUSSION

The finding that there are significant inter-relationships between the psychologically defined variables, but that these bear no significant relationship with the course of pregnancy, is the most outstanding feature of this study. It is significant because it does not confirm with this sample and these measures, findings from other studies, which are either retrospective, or have not relied on a single variable to define the medical diagnosis of the course of pregnancy. When the subjects were seen they did not *know* what the course of their pregnancy would be, and so their responses could not have been given in such a way as to rationalize any sickness. The likelihood of such rationalization is a major criticism of those studies which, have gained their information retrospectively by post-natal inquiry into ante-natal circumstances. Therefore, in this prospective study, relationships have been found between those anxiety measures that are essentially contemporary—that is, between bodily symptoms or adopting the sick role, pregnancy worries and anxiety measures. There is, however, no relationship between anxiety and the course of pregnancy established by a subsequent diagnosis. The vomiters have more pregnancy worries and a lower extraversion score than the non-vomiters.

It is important that the length of labour, in the non-toxaemic group, is related most closely to the size of the family from which the subject comes, suggesting that this variable depends on prior experience with other pregnancies which influences attitudes, or on some genetic factor. Clearly, subsequent studies should include details of the subjects' own mothers' experiences.

In the toxaemic group, although there are no significant relationships between the severity of toxaemic and the personality variables, there are relationships with the measures that assess the wife's view of her husband's

characteristics, more severe toxaemia being related to reports of some negative attributes in the husband, suggesting that contextual factors may be important. Hetzel *et al.* (1961) found in their toxaemic group that the husbands were 'inadequate providers' and rejected the pregnancy. There is also a negative correlation here with the number of siblings.

The most general conclusion is therefore that the personality and social factors that have been considered influence the extent to which there are florid symptoms during pregnancy, but that neither the symptomatology, nor the associated anxiety, were related significantly to the course of pregnancy. Alternatively, it could be asserted that the course of pregnancy is necessarily related to factors of anxiety or stress, in accordance with a general psychosomatic hypothesis, and to conclude that the psychological and other variables measured have not allowed a prediction to be made to the psychological context involved in, for example, the length of labour. That is to say, if there is the relationship that the psychosomatic hypothesis demands, then the variables considered here are not the most appropriate ones to assess it. This interpretation seems plausible because in the interview material, which is to be reported separately, there are differences between the high and low bodily symptom groups.

This conclusion can be seen as further evidence for the difficulty of predicting from a psychological context to a physiological one. It does not imply that there are *no* relationships between psychological and physiological variables in a study like this, but that the identification of such relationships is difficult. Would it not have been surprising to have found a close relationship between, for example, anxiety and the length of labour? Such a finding would have presupposed a much more open system of personality organization than is, in fact, likely. Because the variables assessed here have not been derived empirically for the specific task of differentiating between diagnostic groups, it is unlikely that a close relationship would have

been found as it would presuppose a causal relationship between psychological factors and illness, instead of the much more likely predisposing relationship. This notion of psychological factors predisposing illness is easier to integrate theoretically than is a causative theory (Hinkle, 1961).

There is a need to repeat such studies as this, using psychological variables that have a clearer functional relationship with the physiological variables, than through the medium of self-report of experience. Alexander's (1961) recent work on hyperthyroidism moves in such a direction. Variables like the G.S.R. may be helpful, but the development of an adequate theory of emotion that is not phenomenological is necessary before specific hypotheses can be formulated. Without such a theory, one is, when studying the psychological factors in pregnancy, in the same situation as those earlier personality theorists who relied on physique or physiognomy to give a foundation to their theories, and yet were unable to define how the transition was to be made from the physiological system to the psychological one.

Martin (1961) concludes from the researches he reviews that 'despite many suggestive leads, . . . (no) clear-cut pattern of physiological behavioural responses associated with anxiety arousal, distinguished from other arousal patterns, has been demonstrated.' His survey covers largely autonomic processes, and although no measures of general arousal have been included in this study, a similar conclusion emerges from the lack of any clear relationship between the factor of anxiety on the one hand and either labour time, or the severity of toxaemia, on the other. Perhaps it could be argued that the whole investigation and particularly the measurement of anxiety should have been made nearer to the actual time of delivery, although it is unlikely that this would have produced different results because there were no relationships between the number of weeks pregnant when the data were collected, and any of the other variables (the correlation of this variable with manifest anxiety is -0.08).

Despite the poor relationships with conventionally obtained scores, when the inventory items are considered, there are a number of them which give significant differences. The clearest pattern distinguishes the toxaemic group on the basis of their greater tendency to worry, and suggests that by appropriate grouping of items it should be possible to predict those who will develop toxaemia. The greater social disturbance of the toxaemic group is shown also in the significant correlations with variables relating to the husband and the length of time married, in which the relationships are negative, showing more severe toxaemia among those married for a shorter time.

SUMMARY

In this prospective pregnancy study, psychological variables of a personality or social kind have not been found to have a definite relationship with the course of pregnancy except in the case of those people who developed pre-eclamptic toxaemia. This suggests either that there is no such relationship, or that the psychological variables used are too coarse. However, within a psychological context there are good relationships which could lead to the elucidation of some of the correlates of anxiety in pregnancy. Thus, although there is a series of manifestations of anxiety during the last trimester of pregnancy, these are not related to the length of time in continuous labour.

So far as the specific hypotheses are concerned, the first is not supported as no relationship between anxiety and the course of pregnancy was found, and the second hypothesis is confirmed in that there is a tendency for the more anxious to present more bodily symptoms. The vomiters are not more anxious generally than the non-vomiters although they do have more pregnancy worries and are less extraverted. The M.M.P.I. lie score bears no relation to any of the criterion groups, while the toxaemic group shows greater social disturbance than the non-toxaemic group.

REFERENCES

ALEXANDER, F. *et al.* (1961). Experimental studies of emotional stress. I. Hyperthyroidism. *Psychosom. Med.* **23**, 104.

BROWN, L. B. (1964). Social and attitudinal concomitants of illness in pregnancy. In the Press.

COPPEN, A. J. (1958). Psychosomatic aspects of pre-eclamptic toxaemia. *J. Psychosom. Res.* **2**, 214.

COPPEN, A. J. (1959). Vomiting of early pregnancy: psychological factors and body build. *The Lancet*, 24 January, p. 172.

CRAMOND, W. A. (1954). Psychological factors of uterine dysfunction. *The Lancet*, 18 December, p. 1241.

DALTON, K. (1960). Early symptoms of pre-eclamptic toxaemia. *The Lancet*, 23 January, p. 198.

DAVIDS, A., DE VAULT, S. & TALMADGE, M. (1961*a*). Psychological study of emotional factors in pregnancy: a preliminary report. *Psychosom. Med.* **23**, 93.

DAVIDS, A., DE VAULT, S. & TALMADGE, M. (1961*b*). Anxiety, pregnancy and child-birth abnormalities. *J. Consult. Psychol.* **25**, 74.

EYSENCK, H. J. (1958). A short questionnaire for the measurement of two dimensions of personality. *J. Appl. Psychol.* **42**, 14.

HETZEL, B. S., BREUER, B. & POIDEVIN, L. O. S. (1961). A survey of the relations between common antenatal complications in primiparae and stressful life situations during pregnancy. *J. Psychosom. Res.* **5**, 175.

Hinkle, L. E. (1961). Ecological observations of the relation of physical illness, mental illness, and the social environment. *Psychosom. Med.* **23**, 289.

Martin, B. (1961). The assessment of anxiety by physiological behavioural measures. *Psychol. Bull.* **58**, 234.

Mechanic, D. & Volkart, E. H. (1961). Stress, illness behaviour, and the sick role. *Amer. Sociol. Rev.* **26**, 51.

Poidevin, L. O. S. (1960). Weight gain in pregnancy. *Med. J. Aust.* 27 August, p. 324.

Rosengren, W. R. (1961 a). Some social psychological aspects of delivery room difficulties. *J. Nerv. Ment. Dis.* **132**, 515.

Rosengren, W. R. (1961 b). Social sources of pregnancy as illness or normality. *Soc. Forces*, **39**, 260.

Sarason, I. G. (1960). Empirical findings and theoretical problems in the use of anxiety scales. *Psychol. Bull.* **57**, 403.

Taylor, J. A. (1953). A personality scale of manifest anxiety. *J. Abnorm. Soc. Psychol.* **48**, 285.

Winokur, G. & Werboff, J. (1956). The relationship of conscious maternal attitudes to certain aspects of pregnancy. *Psychiat. Quart.* (Suppl.), **30**, 61.

A pseudo-schizophrenic hysterical syndrome

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The diagnosis of 'hysteria' has been made in 278 cases admitted to the York Clinic, Guy's Hospital, during the last 5 years. The mode of illness ranged from a single conversion symptom to a variety of clinical pictures of great complexity. Within this broad spectrum we have noticed a similarity in the presentation of certain more severe cases, thirteen of which form the basis of the present paper. Our attention was drawn to these patients, who were all women, by the extreme destructiveness of their illness both to themselves and to those around them, and by the excessively demanding yet singularly unrewarding therapeutic programmes which they had elicited from their doctors. Furthermore, although the illness was hysterical, its symptomatology and course were such that in every case a diagnosis of schizophrenia had at some stage been made.

The justification for regarding hysteria as a syndrome was examined in a recent twin study by Slater (1961). He rightly concluded that, while dissociative mechanisms undoubtedly could 'lead to symptoms which deserve no other name', the mere recognition of hysterical symptoms implied no more than that the case belonged to a heterogeneous group of difficult clinical problems. Chodoff & Lyons (1958), discussing the relationship between dissociative reactions, hysterical conversion symptoms, anxiety-hysteria and the hysterical personality, achieved some clarification by divorcing personality from symptomatology. In view of the criticism which this dichotomy has received (Berblinger, 1960), it is of interest that

patients in the present series seldom presented with overt hysterical symptoms, yet invariably displayed those personality traits which have been described as characteristically hysterical, notably shallowness of emotional contact and concepts, lability and poorly controlled display of mood, egocentricity and psychosexual immaturity (Chodoff, 1954; Chodoff & Lyons, 1958).

In association with these personality traits, our patients developed symptoms which led to a diagnosis of schizophrenia. There is of course no reason why schizophrenia should not develop in the hysterical personality; nevertheless, it may be extremely difficult in such a case to distinguish schizophrenic symptoms from severe hysterical manifestations. Thus, cases of hysteria have been described in which extreme dissociation produced an external appearance inseparable from schizophrenic withdrawal (Delay, Buisson & Sadoun, 1955). Overwhelming anxiety may precipitate, in predisposed individuals, a disorganization of personality so gross that dissociative defence mechanisms may govern consciousness, memory and temporarily even the whole individual. Stupor may then occur, or various twilight states with dramatic posturing, excessive talk, and scenic hallucinations (Noyes, 1953). A hysterical pseudo-psychosis of this sort may easily suggest schizophrenia.

Conversely, hysterical symptoms occurring in the course of a schizophrenic illness are usually transient and do not obscure the true nature of the disease. There are however certain subgroups of the currently broadening concept of schizophrenia which are less easily distinguished. These are the so-called borderline states (Bellak, 1958) in which the personality remains relatively well integrated and the clinical picture is dominated by neurotic or

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sociopathic disturbances. Bellak includes under this heading pseudo-neurotic schizophrenia (Hoch & Polatin, 1949; Bleuler, 1954) and the comparable clinical states described variously as abortive (Mayer, 1950), ambulatory (Zilboorg, 1956), latent (Forer, 1950), masked (Kiesler, 1952), pre-psychotic (Nielson, 1948) or subclinical (Peterson, 1954) schizophrenia; and pseudo-sociopathic schizophrenia (Dunaif & Hoch,1955; Milburn & Goff,1956).

The psychodynamics and pan-neurotic symptoms of pseudo-neurotic schizophrenia were described originally by Hoch & Polatin (1949). Hoch & Cattell (1959) regarded the condition as 'a definite psychiatric syndrome. ...There is no evidence that it is a transition between psychoneurosis and gross psychotic symptomatology.' Nevertheless, the distinction may be possible only when careful consideration is given to such phenomena as the amount of primary or secondary gain achieved and the nature of the object relationships (Vanggaard, 1958). In hysterical psychoneurosis the primary gain may be total freedom from conscious anxiety, considerable secondary gain in libidinal and aggressive gratification may be extorted from the environment, and object relationships are powerfully maintained and exploited. In pseudo-neurotic schizophrenia on the other hand, anxiety is diffuse and global, the ability to derive pleasure is lost, and attachments are feeble. In pseudo-sociopathic or pseudo-psychopathic schizophrenia, in addition to neurotic symptoms and diffuse anxiety, anti-social behaviour masks the underlying schizophrenic psychopathology.

The difficulties of distinguishing the severe psychoneurotic from the schizophrenic with florid neurotic symptomatology have been nicely pointed by Roth, who suggested that his own phobic anxiety-depersonalization syndrome might so closely resemble pseudo-neurotic schizophrenia that the latter could properly be described as 'pseudo-schizophrenic neurosis' (Roth, 1959).

The syndrome which we call 'the grave neurosis' also presents in this diagnostic area, having certain elements in common with both pseudoneurotic schizophrenia and the anxiety-depersonalization syndrome. We suggest, however, that it is a distinct clinical entity, fundamentally hysterical, and of grave prognostic significance.

CASE-HISTORIES

The following two case-histories show the clinical features common to the series.

Case 1. A doctor, unmarried, aged twenty-seven.

The patient was the elder of two children of a psychopathic itinerant journalist whose infrequent appearances at home were marked by violent quarrels with the patient's mother. The father showed a complete lack of interest in his daughter. Her own feelings towards him were further betrayed when, at the age of twelve, she discovered him committing adultery with her mother's chronically anxious sister. Her parents divorced and both remarried. The patient lived with them alternately until, at 14, she was sent to boarding school and thereafter spent the holidays with grandparents. She was 20 when her mother died. Of this she said: 'There was never much feeling between us, so I didn't feel upset.' Her relationship with her brother was similarly lacking in affection. Her health throughout childhood was marred by attacks of asthma.

The patient's scholastic record was excellent and she obtained an honours degree in medicine at 24. During her first post-graduate appointment, however, she began to experience symptoms of the present illness which ultimately prevented her from completing her second appointment. From the age of 21 she had numerous sexual experiences, a pregnancy being terminated by abortion when she was 23. In discussing her relationships with men, she stressed the superficiality of these experiences and her almost complete sexual anaesthesia. Her premorbid personality was characterized by poverty of emotional response both in her sexual and social contacts, although an early passivity and shyness were replaced in later years by an aggressive hostility directed particularly against authoritarian figures.

The patient first sought medical advice when aged 26 because of persistent insomnia and loss of interest in her work and in her personal relationships. She described an increasing and curiously distressing sense of mental numbness which eventually led to suicidal ruminations. She consulted the superintendent of a local mental hospital and soon after, whilst under his care, took an overdose of Nembutal 'to get some relief from the feelings of isolation and emotional anonymity'. She was admitted to the hospital with a diagnosis of depression and remained there for a year.

During the first 4 months she was treated with intensive psychotherapy, and with imipramine and E.C.T. She became increasingly disturbed and unable to utilize the psychotherapeutic relationship. During the next 8 months she received further physical treatment, including high dosage with trifluoperazine, E.C.T. and continuous narcosis; but her condition deteriorated. She described terrible feelings of inadequacy and of 'nothingness, meaninglessness, and a lack of feeling so severe that I cannot be depressed'. She said that people looked like waxworks and that she felt blind and emotionally dead. She developed a strong negative transference for the members of the staff who had been engaged in her treatment. A diagnosis of schizophrenia was made and at her request the patient was transferred to a psychiatric unit in a teaching hospital.

Here she at first received physical treatment, including E.C.T., L.S.D. and stimulants. She maintained throughout, as she had at the previous hospital, that treatment would be of no avail unless she could have psychotherapy from the head of the psychiatric department. However, she grudgingly accepted treatment from a registrar who combined psychotherapy with the administration of lysergic acid and cannabis indica. The drugs were regarded by the patient as 'an assault on my personality and integrity', and she became more insistent that she could be helped by no one but the head of the department or the superintendent of the previous mental hospital. During interviews it was clear that the patient was engrossed by the disturbed parental relationship which had marred her childhood.

A conspicuous and constant feature was her lack of will to continue living: 'I would like to sleep or die, there is no difference'; 'When I get enough energy I will go and commit suicide.' She became from time to time acutely disturbed and hostile. In the course of further psychotherapy directed towards an elucidation of her relationship with her father and its bearing on her present symptoms, the patient left the clinic without warning. During her last interview she had thanked the registrar who conducted the psychotherapy but informed him that it was useless. The next day she presented herself at her local mental hospital, where she was re-admitted. That night she took an overdose of sleeping tablets, which she had secreted, and was found next morning dead. In all she had been receiving treatment for 18 months.

Case 2

The patient was a small, dark woman aged 32. She wore ornately-framed, tinted spectacles and affected a certain air of mystery and allure.

As a child, her home life had been unhappily dominated by an autocratic and harshly punitive father. The latter's sexual promiscuity led to repeated miserable recriminations from the patient's mother, a subdued and colourless woman who was apparently incapable of warm affection. The father finally left home to live with a mistress when the patient was 29, and died 2 years later. The patient quarrelled frequently with her two older sisters and brother and had no close relationship with them or with other children. Her brother suffered from asthma and one sister was described as 'an anxious neurotic'.

The patient's academic record was average and she matriculated at sixteen. There followed a period of indecision regarding her future. She entered art school, quickly moved to a polytechnic to study architecture, but after 2 years changed to dress design. Then, at her father's insistence, she entered dental

school, only to leave after one term to begin a secretarial course. When she was 25 she began work on the staff of a woman's magazine. Two years later, after a quarrel with the editor, she left and thereafter found irregular employment in a variety of secretarial jobs.

Soon after starting work she began a stormy relationship with a married man, which persisted intermittently despite frequent promiscuous adventures undertaken, she explained, 'to make him jealous'. She was frigid throughout this time and never achieved orgasm.

She was a sociable person with a shifting population of superficial friends, none of whom became close. Her mood was generally one of mild apprehension, but she was liable to sudden mood-swings and outbursts of temper. She held her rapidly changing beliefs with an evanescent passion and defended them with violent argument.

In 1958, at the age of 29, and shortly after her father's departure from home, the patient developed an hypochondriasis which eventually became localized to her genitalia. She also had attacks of faintness, vomiting and pain in the chest and limbs, for which she was admitted to a general hospital. No physical cause was found for these attacks which were regarded as 'hysterical'. Their recurrence at intervals during the next year, together with increasing depression, led to her referral to a psychiatric day hospital. Here she began taking sodium amytal.

She was transferred to a rehabilitation unit after 3 months, but one week later became 'delirious' and was admitted by way of a general hospital to a mental hospital. She was over-active, shouting and screaming, excited, confused, and described as 'psychotic'. E.C.T. produced an improvement in her mental state and she was allowed to leave hospital. The following day she made a suicidal attempt with sleeping tablets.

Thereafter she was under continuous psychiatric care. She remained mostly at home, but from time to time her behaviour became so distressing and unmanageable that she was admitted for short periods to local mental hospitals where she was usually given E.C.T. or phenothiazines. On one occasion her admission followed a further overdose of sleeping tablets. Overall, there was no improvement in her mental state. She complained of a constant feeling of helplessness, emptiness, remoteness and fear. Diagnoses made at various times during this period included chronic anxiety-hysteria, agitated depression, and catatonic schizophrenia.

On admission to this hospital in August 1961, the patient was agitated and aggressive, alternately screaming and weeping, and crying out: 'I am dead; my mind is dead. I am completely cut off from the world and everyone in it and I can't convey this to anybody.' She became quieter within the day, but emotional storms of this nature recurred frequently, often when relatives visited. In the interim periods she was calm and co-operative, although describing in a vivid and dramatic manner feelings of depersonalization and hopelessness: 'I want to scream and scream for help, but there is no help so I cannot scream, so nobody has any idea of the extent of my condition.' She described visual hallucinations, including a television screen on the front of the doctor's desk and small animals running about the floor. She was not at this time experiencing drug withdrawal effects. On the ward she was helpful, amusing and took a leading part in social activities. Psychotherapeutic interviews invariably produced a release of highly emotional material relating to her psychosexual conflicts and parent/sibling relationships, especially her marked ambivalence to her father.

As her treatment moved towards her discharge from hospital she became increasingly hostile and less co-operative, emotional outbursts recurred, and the therapist was finally rejected when the patient discharged herself in anger. Thereafter she has remained at home, disconsolate, with occasional aggressive outbursts, unemployed, and attending the out-patient department at irregular intervals.

CLINICAL FINDINGS

(Appendix: Tables 1 and 2)

The above case-histories illustrate the salient clinical features which were present, to a greater or lesser degree, in the remainder of the thirteen cases:

(1) *The patients were all women*

The youngest was 22, the oldest 39 (mean age 29 years).

(2) *Parental unhappiness and paternal hostility*

The early family background was unhappy. In every case the father's attitude to the patient was one of punitive hostility or rejection. In eleven cases there was open parental disaffection or quarrelling, and in seven of these separation by divorce (3) or death (4).

A family history of mental disorder was obtained in seven cases:

Case 1. Father: aggressive psychopath.
Maternal aunt: chronic anxiety.
Case 2. Sister: chronic anxiety.
Case 3. Mother: depression, suicide.
Brother: schizoid psychopath.
Case 6. Mother: depression.
Case 9. Paternal aunt: schizophrenia.
Case 10. Father: aggressive psychopath.
Brother: schizoid psychopath.
Case 13. Maternal uncle: psychopathy, addiction, suicide.
Maternal aunt: psychopathy, addiction, suicide.

(3) *Lonely childhood*

Loneliness, described in every case, was not due to physical isolation. It resulted rather from fear of emotional betrayal which prevented the patient from establishing warm relationships with sibling or others, so that she felt distant and different.

Nine patients were the youngest in the family and one was an only child.

(4) *Poor work record despite average or superior intelligence*

These patients did well scholastically but did not fulfil their early promise, failing either at university or soon after starting work. Twelve patients repeatedly changed their jobs, and there was only one (a doctor) whose brief work record was satisfactory until the onset of the present illness. It is of interest that six patients were of the medical profession (four qualified nurses and two doctors) and another was a medical secretary.

(5) *Psychosexual immaturity*

The menstrual history was normal but failure to achieve normal adult heterosexual adjustment was shown in every case by frigidity, and sometimes promiscuity with orgasmal disappointment. Three patients were married. The choice of husband appears to have been made on the basis that he should differ, physically and temperamentally, in every possible way from the patient's father.

(6) *Significantly abnormal personality*

Ten were designated 'immature hysterical' and three 'schizoid' persons. The former made easy, amusing, superficial contact and were generally popular. Gradually, however, their egocentricity, shallowness of emotional contact, affective lability and excessive display became increasingly apparent and those who knew them well became wary of them. Similar personality traits were also present and from time to time conspicuous in the patients who had been called schizoid, but tended to be overshadowed by a pervading attitude of resentful mistrust which resulted in relative social isolation.

(7) *Previous health*

No patient had had serious physical illness, but two had suffered from 'psychosomatic' conditions: one asthma, the other psoriasis.

Seven patients had a previous episode of depression (4) or depression with paranoid features (3). In three cases treatment included E.C.T.

(8) *Prolonged, episodic, severe illness*

When first seen by us, these patients had been ill from 1 to 7 years.

The course of the illness was marked predominantly by gross and characteristic fluctuations in the mental state. The onset, however, at a time when the patient was faced with inescapable and increasingly adult responsibilities, was insidious, with increasing depression, apathy, anergia, inability to care about work or personal relationships, and a sense of inadequacy and helplessness. Multiple somatic complaints without physical basis in seven cases led to frequent visits to the general practitioner.

Episodes of depersonalization and derealization, mild and fleeting in five cases, prolonged and intensely distressing in eight, were experienced chiefly as feelings of numbness, anonymity and isolation expressed in such phrases as 'I feel emotionally blind and dead', 'My mind is dead', 'I have not got any personality at all', 'I am cut off from the world', 'People look like waxworks.' The sense of remote emptiness, and 'lack of feeling so severe that I cannot be depressed', were curiously unpleasant and gave rise in some cases to thoughts of suicide.

The diminution in the patient's occupational and social competence in the face of her symptoms produced in its turn an exacerbation of misery and self-reproach. Some temporarily pleasing or flattering social situation, however, would result in facile, light-hearted vivacity, the patient later declaring that her gaiety at the time concealed an abiding inner despair.

As the patient became more and more preoccupied with her own psychological distress, self-reproach was replaced by a resentful unhappiness in which other people were blamed for not understanding, or caring, or doing anything to help. A true appreciation of her own situational distress or the effect of her illness on those about her, or of their often considerable efforts to help, was lacking. In an unsuccessful effort to obtain relief, increasingly large amounts of barbiturate were consumed. Ultimately, deliberate overdosage constituted the patient's first suicidal attempt. This did not involve serious risk to life, but resulted in the patient's referral to a psychiatrist and, in three cases, the first admission to mental hospital.

Thenceforward, the illness pursued a downhill and increasingly disruptive course. Acute episodes of disturbed behaviour, occurring in relation to any therapeutic pressure or social demands, were common. In these emotional storms, vivid, dramatic, exhibitionistic behaviour culminated in outbursts of weeping, shouting, and screaming, reminiscent of the temper tantrums of a frustrated child and sometimes associated with aggressive and destructive violence or a suicidal attempt. Generally, however, the patient emerged from these crises less scathed than those about her.

Between these acute disturbances the patient's apparently cheerful social appearance contrasted markedly with her complaints at interview of constant tension and despair. It was characteristic that the patient's description of her feelings was couched in vivid terms, presented sometimes intensely, sometimes blandly, but accompanied always by bitter complaint of her total inability to convey the extreme poignancy of her suffering to the therapist: 'It is such a complicated agony locked up inside me, I can't tell anybody. I am beyond help.' The impression was not so much that of deep depression as of an importunate anguish without content. The failure of therapy to provide relief led to increasing demands from the patient coupled with more openly expressed hostility and an aggressive testing out of the therapist to try the limit of his endurance: 'You can't help me, can you?'; 'I'm worse and you don't know what to do'; 'You are too young'; 'You will get tired of me and have me thrown out.' This was accompanied by a quasi-paranoid resentment: 'Nobody understands or does anything to help', 'You don't care', 'Everybody cares about everybody except me'; and sometimes by regressive behaviour: 'I don't know how to get up or wash or dress myself any more. Help me. Please help me.'

Visual hallucinations were an inconstant feature occurring in five patients. These were of a bizarre, complex, scenic nature, sometimes

accompanied by appropriate auditory halluci-nations. While stating that these were real visions, no patient consistently behaved as if the hallucinated scene were actually present.

The patient's attempts to involve and mani-pulate relatives and hospital staff increased *pari passu* with her diminishing ability to deal with her life on a reality basis. The idea of suicide became more insistent and acquired an inevitability in the patient's mind. It was fre-quently spoken of as an absence of desire to live, rather than a positive desire to be dead: 'What else is there to do?'; 'I do not want to go on. Living is just suffering; and nobody cares.' In this situation the paradoxes which these patients present became strikingly apparent as an agony of lack of feeling, vividly conveyed with bitter complaints that it could not be communicated; a desperate need for acceptance and love that was insatiable because less than total surrender was perceived as betrayal and proffered help was tested out to the point of destruction; and finally a curious, qualitative appearance of shallowness in a suffering which nevertheless found no relief and culminated in attempted suicide. Five of these patients ultimately committed suicide. The remainder have each made at least two suicidal attempts. Five patients are still receiving treatment and the remaining three, refusing further treatment, are existing out of hospital at an extremely low socio-economic level.

(9) *Diagnostic difficulty*

Although the illness was regarded ulti-mately as hysterical, at some stage in every case a diagnosis of schizophrenia was made. This occurred following an acute episode (four cases) in which the patient's apparent in-accessibility and sometimes negativistic and symbolic behaviour suggested catatonic schizo-phrenia.

More commonly, however (nine cases), schizophrenia was diagnosed following a long period of unsuccessful treatment during which the therapist had become increasingly aware of a lack of *rapport*, a failure of communica-tion and an incongruity between the patient's social behaviour, her complaints at interview and her affect, particularly when shallowness of affect suggested schizophrenic flatness.

The impression of schizophrenia was heightened in some cases by the emptiness of the patient's complaints; by the bizarre description of depersonalization phenomena; by the paranoid expansion of 'You don't care' into a general mood of resentful mistrust and suspicion, and thence in anger and self-pity to accusations of 'You hate me' or 'My relatives hate me and want to keep me in hospital because I'm a nuisance to everybody'; and lastly by the occurrence of hallucinations.

(10) *Unsuccessful treatment*

In every case, treatment involved repeated admission to mental hospital, sometimes by way of an observation ward following an acute episode of violent behaviour, sometimes directly from an out-patient clinic or after a suicidal attempt. The patient frequently left hospital again against medical advice after a variable period of mounting tension and hostility directed towards the therapist, other doctors, and the nursing staff.

Every patient received physical treatment (including E.C.T., modified insulin, pheno-thiazines and related drugs in high dosage, or a combination of these) after being diagnosed schizophrenic. Apart from the curtailment of acute episodes, such treatment was ineffective or deleterious.

During the sometimes prolonged course of analytically orientated and supportive psycho-therapy, the difficulties of treatment which form an integral part of the illness became apparent. These patients were unable to utilize constructively any interpersonal relation-ship. The transference remained ambivalent throughout but, with increasing emphasis on the hostile and destructive aspect, both therapy and therapist were progressively rejected.

The patient's ambivalence, her attempts to manipulate and emotionally over-involve the therapist and the nursing staff, and her dis-turbing effect on other patients, mirrored the

disruptive effect of the illness on her own family and necessitated frequent doctor–sister–nurse conferences. The bewildered and emotionally exhausted relatives often projected their own anxiety and guilt on to the therapist, questioning his ability and perseverance, and thus adding fuel to the patient's contention that she could be helped only by personal treatment from the senior psychiatrist in the hospital.

Unfortunately, the long hours spent in therapy with, and discussion about, these patients resulted all too frequently in failure to achieve symptomatic relief, increased demands for attention, and the ultimate threat of suicide.

DISCUSSION

The clinical picture in hysteria is frequently complex, the course prolonged, and the outcome unpredictable. The patient is threatened not merely by the direct disability of her symptoms, but also by the reactions which her often destructively manipulative behaviour may provoke in those about her. The difficulties of treatment have been stressed by Stafford-Clark (1952), who originally drew our attention to the pseudo-psychotic manifestations of the illness.

In the present series of cases, physical treatment of the sort commonly regarded as appropriate in cases of schizophrenia produced a deterioration in the mental state. It seemed worth-while therefore to re-examine those criteria which had led to a diagnosis of schizophrenia and those which had resulted in the illness being regarded finally as hysterical.

The failure of *rapport*, which in many cases gave rise to the first suspicions of schizophrenia, was not in fact the characteristic schizophrenic poverty of *rapport* but a positive, active and hostile rejection of the therapist by the patient. This tended to be masked, however, by verbal imprecision and incommunicativeness, possibly based upon impairment of emotional concept formation (cf. Berblinger, 1960), and consequent difficulty in verbalizing significant emotional problems. (Case 2, described above, was atypical in this respect.)

Discussion of the transference frequently produced long silences and the complaint 'I just can't talk to you'. One patient, who remained virtually silent throughout many psychotherapeutic interviews with a registrar, finally presented the senior psychiatrist with a wealth of personal information on a tape recorder stolen from his office for this purpose.

This difficulty in the production of highly charged emotional material was in marked contrast with the colourful and histrionic presentation of *symptoms*, especially the absence of feeling, or psychological void, which was described in such terms as: 'I feel like a ball suspended in space with no feelings, no ideas, no opinions, no judgement, no future. I haven't got any personality at all. I am not quite complete. I should not have been born but I am afraid to die.' In schizophrenia, similar complaints may be elicited only by skilful questioning and may then be presented flatly with little affective display. Patients in the present series were on occasion noticeably undemonstrative, but then such complaints as 'I am dead. I can feel nothing' were made readily and in a manner which reminded us of Berblinger's comment that hysterical patients 'overact their underacting' (Berblinger, 1960).

Apparent incongruities in the patient's behaviour, speech and affect, which contributed to the impression of schizophrenia, could also be understood on a basis of failure of emotional concept formation particularly in respect of the patient's role as a mature adult. A puerile egocentricity effectively prevented the understanding and acceptance of adult emotional relationships and responsibilities. Thus, an irresponsibility at variance with the patient's intellectual attainments resulted in unpredictable, impulsive behaviour; while the impression of incongruity was increased by an explosive lability of mood which was itself consistent with the immaturity of the patient's personality structure. Emotional storms, in combination with the characteristic difficulty in verbalization noted above, produced an apparent inaccessibility reminiscent of certain catatonic states.

Careful examination of the mental state, however, failed to reveal at any time thought disorder, volitional impairment or true poverty of affect. Whereas many patients displayed a tendency to paranoid thinking, radiating from a central inability to repose confidence and trust in their parents, none showed firmly held paranoid delusions. Hallucinatory experiences were always visual (sometimes with appropriate auditory components), complex and dramatically symbolic: for example, one patient stated that she was always standing in a broad river upon whose verdant banks the dismembered bodies of cows lay bleeding in the sun.

Hallucinations were a feature in 15 % of Roth's anxiety-depersonalization cases, but these were of the 'private cinema' type (Roth, 1959). Although some of our patients complained of severe depersonalization, they did not have phobic anxiety, obsessional symptoms or personality traits, nor a history of immediate precipitating calamity.

The hysterical basis of the patient's disabilities became increasingly apparent as the illness progressed. Characteristically there was relative freedom from conscious anxiety in respect of the situational disorganization occasioned by the illness, with considerable secondary gain by way of attention and support extorted from those about the patient. Interpersonal relationships, moreover, were always strongly held, although exploited and destructively misused. This was particularly noticeable in the manner in which the patient manipulated the therapeutic team, intensifying the difficulties of treatment, and evoking in the hospital environment the situation well described by Main as 'The Ailment' (1957). The patients in the present series also had much in common with those forming the basis of Main's paper, including their proclivity to be connected with the medical profession, to become 'special' patients, to distress those looking after them, and at the same time to induce in each attendant the feeling that he or she understood more deeply and clearly than any of the others and so had a special ability

and responsibility toward the patient. It might have been of these patients that Pound (1933) wrote:

She who could never live save through one person,
She who could never speak save to one person,
And all the rest of her a shifting change,
A broken bundle of mirrors. . . .

Exacerbations of distress in attendants and relatives were brought about by the patient's repeated suicidal threats and attempts. The high incidence of ultimate suicides (5 cases: 40 %) is of interest in the light of recent emphasis on the separateness of the attempted suicide and suicide populations. Stengel & Cook (1958, p. 129), regarding suicidal acts as incidents in the course of the struggle for existence, recognize that these populations are not sharply demarcated because 'a minority of one finally join the other.' These authors found that three (1·5 %) of 210 cases of attempted suicide subsequently committed suicide during a follow-up period of from four to six years. The only comparable studies are those of Dahlgren (1945) who followed up 237 cases of attempted suicide for up to 12 years and found that 6 % had died by suicide, and Schneider (1954) who found that during 18 years after the attempt by 372 patients the number of suicides was 34 (12 %); conversely, in unselected samples of suicides, the majority (Stengel & Cook, 1958, p. 116, 86 %; Sainsbury, 1955, 91 %) were found to have no history of previous suicidal attempts.

We believe that a number of factors contribute to the position of the present series of patients in the region of overlap of the two populations. They had the following characteristics in common with the majority of Stengel & Cook's cases of attempted suicide. They were women in their third and fourth decades. Parental discord and loss probably played an important though non-specific part in the origin of the suicidal acts. Aggressive–destructive tendencies were common (12 cases). The inherent social-appeal function of the suicidal attempt was often clear. In this connexion it is pertinent to note Stengel's view

(Stengel & Cook, 1958, p. 117) that the majority of those who appear to use this function purposefully show personality features characteristic of hysterics or psychopaths.

In respect of its social appeal significance, the suicidal act may be regarded as an act of communication. It is possible that the semantic difficulty which characterized our patients may be held partly responsible for the apparent shallowness of their suffering, the consequent inefficacy of their early complaints in evoking attention, the need for dramatic action and the final utilization of the suicidal attempt as a desperate plea for social and medical help.

The frequency with which the suicidal attempt was repeated, in marked contrast with the majority of attempted suicides which remain a single act, may in turn be related to the discrepancy between the patients' insatiable need for omnipotence and unqualified love and the inevitably limited acceptance, submission and love afforded by the environment. Thus the repeated attempt may be seen as a repeated appeal for change in the individual's human relationships which were rendered intolerable by the re-enactment of unresolved conflicts of childhood (Stafford-Clark, 1962).

The high incidence of death by suicide is not readily explained. It may be that suicide is overdetermined in these patients by the convergence of appeal and escape (Cohen, 1954) motives with depression and aggressive tension, the 'hypereridism' of Lindemann (1950). Current object relationships, repeating earlier patterns of frustration and rejection, may result in self-punitive redirection of the patient's aggression, originally father-inspired and directed. This accords with Hendin's emphasis of the psychodynamic role in suicide of aggression directed towards an early love object (Hendin, 1951). Clinically, however, we found signs of depression to be present far more often than did Hendin.

The prediction of suicide is notoriously uncertain. Despite Lindemann's notion of suicide as a disease entity requiring epidemiological investigation (Lindemann, 1950), we still would agree with Zilboorg (1936) that 'a suicidal drive is not dependent on or derived from any traditional clinical entity'. Nor can the seriousness of suicidal intent be correlated with particular psychodynamic factors, or predicted with any degree of certainty by projective or other psychological tests. Nevertheless, in the case of any patient expressing suicidal ideas it is the task of the doctor to assess the degree of risk and to decide upon a plan of treatment accordingly. It is important therefore to try to observe clinical categories with prognostic significance in this respect. Stone (1960) has described one such syndrome of serious suicidal intent occurring in men. We believe that our patients constitute another group in which the risk of death by suicide is high.

Recurrent suicidal threats and attempts may necessitate prolonged admission to mental hospital; and this may unfortunately increase the patient's dependency problems. The essential problem of treatment remains that of enabling a crippled personality to deal with the inescapable realities of her external environment in a flexible and adult way, instead of constantly imposing upon reality problems the additional burden of repetitive neurotic patterns of adaptation. The physical treatments so far employed have not proved successful. Leucotomy has been considered in some cases on the grounds of prolonged and resistant illness with marked tension, but rejected in view of the premorbid personality and social setting. Although the results of psychotherapy are uncertain and incomplete, we believe that a combination of interpretive and sustained supportive psychotherapy with situational adjustment provides the greatest hope in treatment. Nevertheless the gulf between intellectual capacity and emotional stability is so great in these patients that the prognosis must be always grave.

SUMMARY

The diagnosis of hysteria is discussed briefly, with particular reference to 'borderline' schizophrenic states.

A hysterical illness is described, occurring in women in their third or fourth decade. Two case-histories are given and the clinical features which characterized thirteen cases are described.

Those features are discussed which, at some stage in every case, led to a mistaken diagnosis of schizophrenia. The problems of treatment are considered in view of the high incidence of death by suicide.

APPENDIX

Table 1. *History*

	Case no.												
	1	2	3	4	5	6	7	8	9	10	11	12	13
Family history													
Parental disharmony	+	+	+	+	+	+	+	+	+	+	.	.	+
Parental separation	+	+	+	+	.	.	.	+	+	.	.	.	+
Father–patient disharmony	+	+	+	+	+	+	+	+	+	+	+	+	+
Youngest or only child	.	+	+	.	+	+	+	+	+	.	+	+	+
Mental disorder in near relative	+	+	+	.	.	+	.	.	+	+	.	.	+
Personal history													
'Lonely' childhood	+	+	+	+	+	+	+	+	+	+	+	+	+
Good/average school record	+	+	+	+	+	+	+	+	+	+	+	+	+
Poor work record	.	+	+	+	+	+	+	+	+	+	+	+	+
Psychosexual immaturity	+	+	+	+	+	+	+	+	+	+	+	+	+
Past physical illness	+	.	.	.	.	+	.	.	.	.	.	.	.
Past mental illness	.	.	+	.	.	.	.	+	+	+	+	+	+
Previous personality													
Hysterical	.	+	+	+	+	+	+	.	+	+	+	.	+
Schizoid	+	.	.	.	.	.	.	+	.	.	.	+	.

Table 2. *Present illness*

	Case no.												
	1	2	3	4	5	6	7	8	9	10	11	12	13
Insidious onset with depression	+	+	+	+	+	+	+	+	+	+	+	+	+
Hypochondriasis	.	+	+	.	.	.	+	.	+	.	+	+	+
Severe depersonalization	+	+	.	.	+	.	+	.	.	+	+	+	+
Acutely disturbed episodes	+	+	+	+	+	+	+	+	+	+	+	+	+
Aggressive/paranoid tendencies	+	+	+	+	.	+	+	+	+	+	+	+	+
Visual hallucinations	.	+	+	.	+	.	+	.	.	.	.	.	+
Difficulty in communication	+	.	+	+	+	+	+	+	+	+	+	+	+
Difficulty in transference	+	+	.	+	+	+	+	+	+	+	+	+	+
Involvement of staff	+	+	+	+	+	+	+	+	+	+	+	+	+
Suicidal attempts	+	+	+	+	+	+	+	+	+	+	+	+	+

APPENDIX (*cont.*)

Table 2 (*cont.*)

Diagnosis/treatment

Diagnosed schizophrenia	+	+	+	−	·	·	−	·	·	·	··
Diagnosed depression	+	+	·	·	·	·	·	·	·	·	··
Diagnosed hysteria	+	+	·	·	·	·	·	·	·	·	··
E.C.T./phenothiazines given	+	+	−	−	+	·	·	−	·	·	·

Outcome

Social deterioration	·	+	·	·	+	··	−	·	·	·	·
Suicide	←	·	+	··							

REFERENCES

BELLAK, L. (1958). *Schizophrenia: A Review of the Syndrome*, p. 147. New York: Logos Press.

BERBLINGER, K. W. (1960). *Dis. Nerv. Syst.* **21**, 386.

BLEULER, M. (1954). *Amer. J. Psychiat.* **111**, 382.

CHODOFF, P. (1954). *Amer. J. Psychiat.* **17**, 75.

CHODOFF, P. & LYONS, H. (1958). *Amer. J. Psychiat.* **114**, 734.

COHEN, E. A. (1954). *Human Behaviour in the Concentration Camp*, p. 162. London: Jonathan Cape.

DAHLGREN, K. G. (1945). *On Suicide and Attempted Suicide*. Lund: Lindstedt's.

DELAY, J., BUISSON, J. F. & SADOUN, R. (1955). *Encephale*, **44**, 336.

DUNAIF, S. & HOCH, P. H. (1955). *Psychiatry and the Law*, p. 169. (Ed. P. H. Hoch and J. Zubin.) New York: Grune and Stratton.

FORER, B. R. (1950). *J. Proj. Tech.* **14**, 297.

HENDIN, H. (1951). *Psychiat. Quart.* **25**, 672.

HOCH, P. A. & CATTELL, J. P. (1959). *Psychiat. Quart.* **33**, 17.

HOCH, P. A. & POLATIN, P. (1949). *Psychiat. Quart.* **23**, 248.

KIESLER, F. (1952). *Bull. Univ. Minn. Hosp. Med. Found.* **24**, 211.

LINDEMANN, E. (1950). *Proc. Ann. Conf. Milbank Mem. Fund*. New York.

MAIN, T. F. (1957). *Brit. J. Med. Psychol.* **30**, 129.

MAYER, W. (1950). *J. Nerv. Ment. Dis.* **112**, 539.

MILBURN, A. A. & GOFF, M. N. (1956). *W. Virginia Med. J.* **52**, 374.

NIELSON, J. M. (1948). *J. Nerv. Ment. Dis.* **107**, 340.

NOYES, A. P. (1953). *Modern Clinical Psychiatry*, 4th ed., p. 455. London: W. B. Saunders.

PETERSON, D. R. (1954). *J. Consult. Psychol.* **18**, 198.

POUND, E. (1933). *Selected Poems*, 2nd ed., p. 143. London: Faber and Faber.

ROTH, M. (1959). *Proc. Roy. Soc. Med.* **52**, 587.

SAINSBURY, P. (1955). *Suicide in London*, p. 64. London: Chapman and Hall.

SCHNEIDER, P. B. (1954). *La Tentative de Suicide*. Neuchatel, Paris: Delachaux and Niesthe.

SLATER, E. (1961). *J. Ment. Sci.* **107**, 359.

STAFFORD-CLARK, D. (1952). *Guy's Hosp. Gaz.* **66**, 240.

STAFFORD-CLARK, D. (1962). Personal communication.

STENGEL, E. & COOK, N. G. (1958). *Attempted Suicide*, pp. 116, 129. London: Chapman and Hall.

STONE, A. A. (1960). *A.M.A. Arch. Gen. Psychiat.* **3**, 331.

VANGGAARD, T. (1958). *Acta Psychiat.*, Kbh., **33**, 251.

ZILBOORG, G. (1936). *Arch. Neurol. Psychiat.* **35**, 270.

ZILBOORG, G. (1956). *Amer. J. Psychiat.* **113**, 519.

School phobia and its treatment

By R. WARNECKE*

INTRODUCTION

Cases of refusal to attend school were first described in the literature by Broadwin (1932) and Partridge (1939). In an analysis of forty truants Partridge (1939) distinguished a group which he designated 'neurotic'. In 1941, Johnson, Falstein, Szurek & Svendsen used the term school phobia but regarded it as an incorrect title. They insisted that the problem was one of separation anxiety. This view has been expressed by many authors. It is important, first of all, to be clear as to what is meant by separation anxiety.

REVIEW OF LITERATURE

A critical review of the psychoanalytical literature on separation anxiety has recently been published by Bowlby (1961). Conceptions of separation anxiety diverge according to the individual psychoanalyst's outlook on the nature and origin of anxiety. Anxiety can be explained as a response to an external threat. The processes involved are regarded as internal and instinctive. How they are to be conceptualized and how they give rise to anxiety remains a puzzle. Bowlby (1961) describes six main approaches to the problem of separation anxiety. Three are related to theories regarding the nature of the child's attachment to his mother. Thus: (i) Freud (1905)—anxiety is observed when an infant is separated from the person he loves because the child's libido remains unsatisfied. (ii) Birth trauma theory (Rank, 1929)—separation anxiety is a reproduction of the trauma of birth. (iii) Signal theory (Freud, 1926)—there are three variants: (*a*) a traumatic situation is caused when there is an accumulation of

excessive amounts of stimulation arising from unsatisfied bodily needs; (*b*) imminence of a total and permanent extinction of the capacity for sexual satisfaction; (*c*) the traumatic situation which must be avoided is narcissistic in nature (Spitz, 1950). (iv) Klein's theory of depressive anxiety (1935)—the child is ambivalent to his mother; when she disappears he has eaten or destroyed her. (v) Klein's theory of persecutory anxiety (1934)—by projection of aggression the child perceives the mother as persecutory. (vi) Anxiety is a primary response not reducible to other terms and due to the rupture of an attachment to the mother. Bowlby (1961) calls this the theory of primary anxiety.

In 1926 Freud concluded that anxiety has two forms: (i) an automatic phenomenon with physiological features which are appropriate to the situation of birth. (ii) Anxiety as a rescue signal designed to indicate that danger is impending. It is the task of the ego to anticipate danger situations. Bowlby (1961) termed this expectant anxiety.

There are therefore different opinions as to the exact nature of what is meant by separation anxiety. However, in applying this to school phobia I would like to make the following observations. It appears that different theories can explain the behaviour of mother or child in their various phases of development. Everyone is agreed that these mothers are afraid of separation of the child from themselves. I suggest that this need not be so in the case of the child. Rather it may be that the mother is projecting a 'complex' on to the child —for example the child may unconsciously represent elements within herself. This interferes with the child's autonomy or freedom to develop in his own way. The mother's anxiety over separation may therefore intensify a

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regressive feeling in the child when he is faced with what may amount to a narcissistic trauma. N. E. Whilde (1960, personal communication) suggests that the child is having to cope with an initiation problem. This might be regarded as physiological in the child who has the task of mastering the tensions which arise in the course of acceptance of collective standards.

The descriptions provided by Coolidge, Hahn & Peck (1957) lend support to this idea of duality. They describe two groups of school phobias.

(1) These authors regard the 'neurotic' group as an acute regressive reaction in the face of an exacerbation of a specific conflict. The conflict grows out of the need to establish autonomy in relation to the mother. Implicit in this maturing is the threatening necessity for the child to attempt to resolve his sexual conflicts. The child wishes to avoid the anxiety-laden oedipal conflict by remaining the dependent asexual baby. This group of cases has attained the phallic phase.

(2) In the 'characterological' group the central conflict revolves around the symbiotic tie with mother. Increasing external pressure and a consequent sense of inadequacy produce feelings of helplessness which in turn increase the yearning for dependence and protection from the mother thus strengthening the regressive tendency. Fears of helplessness are counteracted by a consuming need for control. Such cases, it is hypothesized, are fixated at the pregenital level.

I would comment here that one might think of separation at two levels. In resolving the symbiotic relationship the mother recognizes that she is a person with feelings independent and different from her child. Could this not be similar to the process of birth? The second phase might be regarded as a pushing of the child out of the nest.

Many authors point out that these mothers are unable to recognize or tolerate their hostile feelings. My experience would confirm this. I have seen both processes operate in the same case. A symbiotic relationship between mother and child may be temporarily resolved only to flare up at puberty when the mother had to come to grips with her ambivalent feelings of protecting the child on the one hand as opposed to the feeling that he must stand on his own feet.

These processes can exist in children leading to a situation where they refuse to attend school but manage to get there. I would suggest that if a child does not attend school a more extensive regression has taken place and a different picture emerges. For instance depression may appear. This may account for the descriptions in the literature of a depressive syndrome as described by Agras (1959). The situation in the home is tense, mutually hostile, threatening, fearful and guilty. The parental attitudes move nearer to rejection and in two of the cases to be quoted the situation in the home and the behaviour of the child became so impossible that there was no other choice than placement in an approved school.

School phobia is distinguishable from truancy and these differences have been described by a number of authors (Partridge, 1939; Johnson et al. 1941). Truants are frequently delinquent. The majority run away to escape punishment for some misdemeanour at school. They are afraid to return and do not go. Refusal to return does not become an issue with the parents as in school phobia, nor are there panics in relation to returning to school. Borderline cases do in fact occur.

In relation to treatment I would first like to quote from an article by Rodriguez, Rodriguez & Eisenberg (1959) which reports a follow-up study of forty-one cases. This paper describes the academic and social adjustment of forty-one children with school phobia at a mean (and median) interval of 3 years following their initial contact. Results are presented in validation of a therapeutic method which emphasizes prompt return of the child to school as the key to successful treatment. School phobia is defined phenomenologically as partial or total inability to go to school which seems to result from some dread of the

school situation. Anxiety appears when school is imminent.

Overt expressions of anxiety may be lacking but may be inferred from the correlation of symptoms with school-days and their absence at week-ends or holidays. The child may ascribe his fear to a teacher, his class-mates, or to the dread of failing. These authors considered that the separation problem is 'bilateral', the involved parent initiates and reciprocates the child's anxiety. Observation of the child's symptoms *in statu nascendi* revealed that they were a response to the contradictory verbal and behavioural cues provided by the parents. This resulted in a direct communication of anxiety between the principal actors in the family drama. Eisenberg (1958) has provided further evidence in favour of this hypothesis. The therapeutic implication of this theory of symptom genesis is that the treatment programme should be centred around a firm insistence on early return to school.

There are two schools of thought regarding the treatment of school phobia. Certain workers (Lippman, 1956; Talbot, 1957; Johnson *et al.* 1941; Hersov, 1961) stress the desirability of removing pressure for attendance followed by a period of working through of dynamic issues and then a planned return. Glaser (1959), Eisenberg (1958), Klein (1945) and Waldfogel (1959) emphasize the importance of an insistence upon early return to school after an initial psychiatric evaluation. This is followed by concurrent therapy while the child is at school. Rodriguez *et al.* (1959) have not hesitated to invoke the legal authority of the school to compel attendance when no real movement towards return to school was evident on the part of the family.

The latter view has been criticized on the grounds that recurrence or substitution of symptoms may occur in view of the obvious diminution in the motivation for prolonged treatment once return to school has been accomplished. Waldfogel (1959) followed a group of thirty-six patients for a period of 6–18 months. Twenty of these were treated

briefly. Eighteen continued to attend without recurrence of symptoms and two had but brief bouts of anxiety. They found no evidence of symptom displacement. The outcome was contrasted with eleven cases in six of which treatment was refused by parents and in four of which treatment was unavailable. Of these eleven only three had been able to resume full attendance. Glaser (1959), in a report of thirty-eight cases treated with an emphasis on early return to school, noted that thirty-six were in regular attendance of whom only three had major persisting symptoms after a follow-up period of 1–2 years.

Rodriguez's (1959) clinical material consists of forty-one cases taken from the years 1952 to 1957. There were fourteen girls and twenty-seven boys. In some reports girls are as common as boys while in others girls are more common than boys. The I.Q. distribution was above average. Rodriguez's emphasis was on short-term treatment. Three-quarters of the cases were in treatment for less than 4 months, only one-sixth were treated for as long as 6 months.

Method of study (Rodriguez *et al.* 1959). Telephone and mail inquiry information was sought on attendance record, school achievement, and social adjustment of each patient. Information was obtained from both sources in 90% of cases but from at least one source in all cases. No case was followed for less than 15 months. Three-quarters were revaluated after 2 years and one-half at least 3 years.

Results. The outcome was considered successful only if the child was attending school regularly. By this criterion twenty-nine (71%) were successful. Ninety-three per cent. of the fourteen girls but only 60% of the twenty-seven boys were successful. The apparent sex differential was largely ascribable to the age distribution of the boys and girls. It is noteworthy that once the child has attended school regularly for as long as 1 month further problems in attendance arose in only two. Only 36% of the fourteen children in the eleven or older age group were able to return to school.

On the basis of replies from schools and families, the authors stated that twenty-three of the twenty-nine successful cases were reported to be making satisfactory academic and social progress at an average interval of 3 years after the onset of their treatment experience. The problems described in the remaining six patients centred about aggressive behaviour disorders in three, and academic failure in three (of whom two had I.Q.'s of less than ninety). Follow-up method is likely to have registered the presence of major maladjustments only. It seems significant none the less that functional impairment from phobic or anxious behaviour was not described in any of the twenty-nine successful cases.

An attempt was made to identify the major factors in the therapeutic failure of the twelve children who did not return to school. Primary factors in the poor outcome in twelve cases: schizophrenia, three cases; family decompensation, four cases; inadequate treatment, three cases; medical mismanagement, two cases.

As a group these patients were more disturbed than the others. There were no schizophrenics in the other group. Among the seriously disturbed families four had a psychotic parent in the home and three a totally inadequate father. Efforts by clinic, schools, and other social agencies were unavailing in the search for a point at which therapeutic leverage could be applied in these families. In two of the five a successful outcome might have been achieved but the parents broke off treatment using as an excuse a physician's statement that the children were too nervous to go to school and required home teaching. In three cases there was a failure to establish satisfactory liaison between the clinic and the school.

The following conclusions were reached by Rodriguez et al. (1959). The prognosis is graver for the older child. Salvage rate in children older than 10 does not exceed 50%. The therapeutic programme requires close co-operation between school and clinic. Early

in their work the authors were hesitant to apply pressure. It became clear however that they shared and indeed reinforced family anxieties by their hesitance. As the feared untoward reactions failed to occur they became increasingly aware of the considerable therapeutic value of the insistence on early return itself. It brings into sharp focus the primary issue of separation itself and dissociates the therapist from the family's anxiety about the fantasied dangers connected with the school situation. Secondly it emphasizes a recognition of a core of health in the child. This constitutes effective reassurance to a panic-stricken family. De-emphasis on school attendance and a plan for prolonged therapy tend to signify to the family that the physician is uncertain and regards the child as sick despite statements to the contrary. Finally, return to school restores the child to a growth-promoting environment and removes him from his immersion in the cycle of mutually reinforced anxieties in the home.

All who have worked with cases of school phobia agree on the importance of prompt intervention. Cases should be regarded as semi-emergencies. The longer the absence from school the more entrenched become the original anxieties and the greater the strength of secondary fears about missed school work, the reaction of class-mates and so on. It is noteworthy that Rodriguez et al. (1959) were unable to demonstrate a correlation between the duration of the school phobia and the ultimate outcome. Cases of 3–6 months were successfully returned. Unsuccessful cases, however, presented a considerably longer history of emotional maladjustment before they were brought for treatment.

I would now like to quote from an article by Talbot (1957) which is representative of the school of thought which believes that 'the initial steps for all age levels is to relieve pressure on the child for school attendance. The parents and school personnel are freed from tensions as well. It cannot be too strongly stressed that the therapist must be careful to avoid developing anxiety in himself

in relation to the child's returning to school. The child responds in time to a warm, calm, consistent and firm approach.' Talbot's (1957) impression is that the earlier treatment is begun the better is the prognosis and the timing of returning these children to school determines success or failure of treatment. Talbot also states that if environmental manipulation enables the child to return to school without treatment he may be making an adjustment at the price of displacing his anxieties on to some other situations.

Talbot (1957) has also found that the following temporary plans have proved successful. Mother sits in the classroom, father sits in the car outside the school building, child helps in the school office, child sits near a friend, or remains in school for a brief period each day. She has recorded twenty-four cases, twenty of which were attending school regularly. Two of the twenty are subject to remissions. She gave the age distribution as evenly placed from 5 to 15 years. (This would place the majority below the age of 11.)

SHEFFIELD STUDY

A follow-up study has been carried out in Sheffield of forty-seven cases of school phobia treated by members of the staff of the Child Guidance Centre past and present up to February 1961. Collaborative treatment of mother or father and child has been conducted by various combinations of staff, for example, two psychologists, psychiatric social worker and psychologist, psychiatrist and psychologist. With few exceptions these cases have all been seen for psychiatric assessment. The follow up has been carried out by the Welfare Department and consists of a report on the school attendance and information relating to adjustment. Further information to the same end has been obtained by contacting headmasters. When these children were returned to school successfully this was achieved within a very short period. The date of the follow up has been taken from this point.

Follow-up periods

Years	Cases
6–14	11
3–5	7
2–3	18
1–2	8
Under 1 year	3
Total	47

The results of this inquiry were as follows:

	Cases
Subsequent attendance at school satisfactory, i.e. symptom removed	40
Subsequent attendance unsatisfactory	6
No information	1
Total	47

Turning to the information relating to adjustment, as distinct from removal of the referral symptom, the following state of affairs was reported:

	Cases
Adjusted	23
Improved	13
Not adjusted	3
No information	8
Total	47

As regards the intelligence of the children the I.Q.'s ranged from 65 to 140. The median was 103 and half of them lay between 97 and 118. Only one-quarter lay below 97.

The position in the family is interesting, thirteen (i.e. 29 %) were only children, fifteen were eldest and twelve youngest. These extreme positions accounted for 55 % of the total. Only five (about 11 %) occupied intermediate positions so that the oldest, youngest, and only children account for almost 90 % of the sample.

The age distribution of this series of cases is as follows:

Years	Cases
Over 11	30
10–11	4
9–10	5
8–9	3
7–8	1
6–7	1
5–6	3
Total	47

Thus 64 % were over the age of 11 years. The six children (including two in approved school) whose school attendance was reported as unsatisfactory were all over the age of 11 years which confirms previous observations that the prognosis is adversely affected by age. In these six cases there was no evidence that firm handling was in any way contributory to a poor outcome. In fact the evidence pointed to the reverse being the case. One case had attempted suicide prior to referral. Her depression cleared up with eventual return to school.

It is to be noted that in this selection there are fewer cases in the younger age group (36 %) below the age of 11. This is partly due to the selection of only those cases which have been most acute and associated with persistent refusal. The sex distribution showed a preponderance of girls, who numbered thirty as compared to seventeen boys.

MANAGEMENT AND TREATMENT

Treatment of the above patients in the clinic has been based upon the techniques advocated by Rodriguez et al. (1959). We have regarded the presenting symptom of refusal to attend school as an emergency. Two issues were involved—first getting the child back to school and secondly the background psychopathology. At the outset I would suggest that there is a specific treatment for each individual case and it is the task of the therapist to discover this. It is worth remembering that there are innumerable cases of school refusal which have been successfully handled without referral to a Child Guidance Clinic. More than one author has expressed the view that school refusal is a normal reaction in the process of growing up. It is possible that many parents deal with these problems adequately on their own without external help. Others are worked out with the assistance of head-teachers, family doctors, or welfare officers. When these agencies fail then there is the possibility of the Child Guidance Service becoming involved with an acute situation.

The diagnostic interview is used to assess what steps will be required to gain the child's return to school. In this series no cases were excluded from school. On several occasions where doubt existed a discussion with the family doctor followed, and agreement was reached in all but one case. This child was excluded for 6 months on medical certificate and at the end of that time there was the same panic reaction relating to return to school. Pressure was eventually used with the agreement of all concerned with a successful outcome. Reference has already been made to those authors who report that exclusion leaves this residual problem.

There are occasions when a child should be excluded from school on psychiatric grounds. In one case not included in this series the child was sent to hospital from school because of acute hysteria. The hospital referred the case to the Child Guidance Clinic and the boy was handled successfully by the welfare officer after the parents had been interviewed and had shown a willingness to co-operate.

Apart from determining fitness to attend school it is extremely important to make some assessment of the parental attitude towards collective social standards. Some parents will go to any lengths to support their child's refusal to attend school. There appear to be two groups of parents: those who accept the standards of the community regarding education and those who do not.

In the first group a co-operative relationship develops between the family and psychiatrist and practical plans are worked out when necessary. Thus some parents decide that their child must go to school and are able to manage this, having made the decision, without further advice. The parents may have valuable suggestions to make. Some line of action may then be planned which involves co-operation with the headmaster or the Welfare Department. Thus a change of class may be indicated where the teacher is emotionally involved. The assistance of the welfare officer may be required in some form or other.

If the parents have no suggestions to make it

then becomes a matter of asking whether father or mother could escort their child to school or whether they would like the welfare officer to do this. The welfare officer may go along to the home in order to accompany the child to school to discover that nothing short of force will work. This is discussed with the parents if it has not already been done so previously.

During the diagnostic interview the various emotions that have arisen are identified and an attempt is made to view the fears, guilts and resentments in a proper perspective. There is a marked tendency in most cases towards hysterical dramatization. In the first interview both parents and child are encouraged to live with their emotions in an active way. Fears must be investigated during treatment interviews at a later date. In the meantime the child goes to school putting up with disturbing emotions and tensions. Sometimes it is possible to deal with these affects at an early stage in treatment and I do not think that the importance of this is sufficiently realized. The child is often guilty because he refuses to go to school and he is afraid of what the consequences might be. He is hostile to an authority which expects him to go. In dealing with these situations the ego of the child is supported and the feeling of inadequacy in the parents is diminished. Such an approach does not imply that unconscious determinants are ignored but that they should be dealt with at the proper time.

In this connexion it is important to identify accurately the emotions that have to be examined. Thus one child states that he does not want to go to school, he does not like it. The fact that he 'does not want' is regarded by him as the adequate reason. The parents say that he is afraid but he does not admit to this and all investigations lead to negative results in this respect. The parents are in fact projecting their own emotions on to the child. Thus this father was full of fear of what the neighbours would think if he exerted discipline, while the mother felt guilty.

In the second group of cases it was necessary to introduce some form of pressure in order to encourage the development of collective standards in parents. Guilt over not attending school was neither apparent nor admitted. The children were encouraged by their parents to stay away from school and every attempt was made to achieve this end, subtle deception sometimes being involved. For example a boy had refused to go to school and his mother reported to the teacher that her child was off because of asthma. The family doctor checked on this and said that although the boy did suffer from asthma it was not present at that moment. The welfare officer had also visited and observed that the boy was not suffering from an attack. These situations are extremely difficult to cope with.

With this group of cases the Welfare Department has considerable experience and their co-operation is invaluable. Here again I hold the view that there is a right sort of procedure for the right sort of case. The difficulty is in finding it. For instance the father of the asthmatic boy appeared before the rota committee which consists of welfare officers plus one member of the education committee and members of a panel nominated by various organizations, e.g. Sunday schools, women's organizations, etc. This was effective in this case.

There are two forms of legal action which can be taken. When the parents are obviously culpable and do nothing to co-operate, they may be taken before the magistrates. If the parents have co-operated and done all they can the child may be taken before the Juvenile court and placed on probation, sent into a remand home, or exceptionally sent to an approved school (this has happened twice in the last 10 years), or finally committed to the care of the Local Authority. One child was committed to 'care' and placed in a Home from whence there was regular school attendance without any panic. The patient later returned to his own home and there was no further difficulty.

Comments on Theory and Practice

Treatment of the mother is directed towards achieving independence from the child and vice versa. They are usually identified with their children whom they spoil and overvalue. They are unable to express hostile feelings and they are extremely self-critical regarding negative feelings of any sort. When they are able to tolerate separation from their children the major problem of treatment is solved. An excellent example of this turning point appears in an article by Pappenheim & Sweeney (1952). They state:

Michael in play interview became aggressive and provocative. He broke up picture puzzles, scattered the pieces all over, seemed determined to destroy things, opposed the therapist in every way. Without warning he dashed downstairs to his mother and hid behind her chair. As though struck by a force beyond her control Mrs G. launched into a tirade against Michael. He was making a fool of her. She didn't care if he were her own flesh and blood she would make his life as miserable as he was making hers. She burst into tears, arose from her chair as if to leave. Michael stunned by the suddenness of his mother's anger crouched into the corner and sobbed loudly. Michael's recovery from this ordeal was phenomenal. Separation was achieved. Follow up two years later all was well.

These mothers have to be helped to achieve independence of their own mothers; it has been pointed out that they frequently live close to each other, or at least are able to make frequent contact.

In cases of school phobia there is a difference between mother–son and mother–daughter relationships. The daughter may have a strong tie to a dominating mother and a weak one to the father. In a case of this sort the father stays away from work on the slightest pretext. On the other hand the mother may have to cope with an abnormal relationship between father and daughter. This is discussed by Klein (1945). Almost all writers are agreed that the mothers are 'inadequate' and de-

pendent and thus treatment becomes concerned with demonstrating to them their lack of confidence in their judgements and feelings.

Most authors describe the mothers as ambivalent. The difficulty here is that this term is used with different meanings. Model & Shepherd (1959) present the view that the mother has to compensate for hostility by overindulgence. Estes, Haylett & Johnson (1956) refer to unconscious hostility towards the child. Kahn (1958) bases himself on Melanie Klein's theories (1935) and associates ambivalence with simultaneous love and hate. Davidson (1961) regards ambivalence in the sense that love and hate exist side by side. Waldfogel (1957) states that the mother's affection appears primarily and spontaneously and it is not simply an attempt to deny her hostility.

The issue appears to resolve itself into two viewpoints in relation to the love shown by these parents: (1) love is compensatory; (2) love exists in its own right. There are mothers who rationalize (which I regard as compensatory) to prove how much they love their children when they have little feeling. This did not appear in the cases of this series, nor does it seem to apply to those described in the literature in general.

There is insufficient distinction in the literature between what is conscious and what is unconscious. From the clinical point of view it is essential to try and make this distinction. If a mother produces material which is oversolicitous (as is so common in these cases) it may be desirable to deal with this at its face value. One may have to discuss, for example, whether it is wise for her to continue blacking her son's shoes. Approaching the problem in this manner does not stop the mother from coming to grips with hostile feelings when the occasion demands. It is my view that these mothers are not 'rejecting' in the sense that love is a compensation for hate. I would think that their love is inadequate and anger often results from feelings of exasperation and helplessness.

Waldfogel (1957) points out that the parents

of these children are always at hand to protect the child from painful situations. The mother tries to protect him from pain, shock and frustration. She goes to considerable trouble planning to prevent his coming into contact with the painful facts of life. By her excessive preoccupation with her child's welfare and her inability to set effective limits the mother feeds the child's narcissism and omnipotent fantasies. Waldfogel (1957) also refers to the fact that the father is unable to fulfil the paternal role. At times it is as if the child has two anxious mothers. The father tries to prove he can handle the children better than his wife thus undermining her shaky foundations of motherhood.

One must always keep in mind that these children have lacked the opportunity to test the real consequences of distressing emotions. It becomes a matter of coming to grips with the painful facts of life, such as fears of teachers, of other children, of failure, of ill health, of their own emotions as well as other people's.

REFERENCES

AGRAS, S. (1959). The relationship of school phobia to childhood depression. *Amer. J. Psychiat.* 533.

BOWLBY, J. (1961). Separation anxiety: a critical review of the literature. *J. Child Psychol. Psychiat.* 4, 251.

BROADWIN, I. T. (1932). A contribution to the study of truancy. *Amer. J. Orthopsychiat.* 2, 253.

COOLIDGE, J. C., HAHN, P. B. & PECK, A. L. (1957). School phobia. A neurotic crisis or way of life. *Amer. J. Orthopsychiat.* 27, 307.

DAVIDSON, S. (1961). School phobia. *J. Child Psychol. Psychiat.* 4, 270.

EISENBERG, L. (1958). School phobia. A study in the communication of anxiety. *Amer. J. Psychiat.* 114, 712.

ESTES, H. R., HAYLETT, C. H. & JOHNSON, A. M. (1956). Separation anxiety. *Amer. J. Orthopsychiat.* 10, 682.

FREUD, SIGMUND (1905). *Three Essays on Sexuality.* Standard edition, no. 7.

FREUD, SIGMUND (1926). *Inhibitions, Symptoms and Anxiety.* Standard edition, no. 20. Hogarth Press, London, 1929.

GLASER, K. (1959). Problems in school attendance. *Pediatrics,* 23, 371.

HERSOV, L. A. (1961). Non-attendance at school and refusal. *J. Child Psychol. Psychiat.* 2, 130.

JOHNSON, A. M., FALSTEIN, E. I., SZUREK, S. A. & SVENDSEN, M. (1941). School phobia. *Amer. J. Orthopsychiat.* 11, 702.

KAHN, J. H. (1958). School refusal. *The Med. Off.,* p. 337.

KLEIN, E. (1945). Reluctance to go to school. *Psychoanal. Study Child,* 1, 263.

KLEIN, M. (1934). On criminality. *Developments in Psychoanalysis.* Hogarth, 1952.

KLEIN, M. (1935). A contribution to the psychogenesis of manic depressive states. *Contributions to Psychoanalysis.* Hogarth, 1948.

LIPPMAN, H. S. (1956). *Treatment of the Child in Emotional Conflict.* New York: McGraw-Hill.

MODEL, A. & SHEPHERD, E. (1959). The child who refuses to go to school. *The Med. Off.,* p. 39.

PAPPENHEIM, E. & SWEENEY, M. (1952). Separation anxiety in mother and child. *Psychoanal. Study Child,* 7, 95.

PARTRIDGE, J. M. (1939). Truancy. *J. Mental Sci.* 85, 45.

RANK, O. (1929). Trauma of birth. Kegan & Paul, London.

RODRIGUEZ, A., RODRIGUEZ, M. & EISENBERG, L. (1959). The outcome of school phobia. *Amer. J. Psychiat.* 116, 540.

SPITZ, R. A. (1950). Anxiety in infancy, a study of its manifestations in the first year of life. *Int. J. Psychoan.* 31, 138.

TALBOT, M. (1957). Panic in school phobia. *Amer. J. Orthopsychiat.* 27, 286.

WALDFOGEL, S. (1959). Quoted by Rodriguez as a personal communication.

WALDFOGEL, S., COOLIDGE, J. C., HAHN, P. B. & LIPPMAN, H. S. (1957). The development, meaning and management of school phobia. *Amer. J. Orthopsychiat.,* p. 754.

Reviews

Problems of Psychiatry and Neurology. Transactions of the Leningrad Scientific Society of Neurologists and Psychiatrists. Vol. III, ed. by I. F. SLUCHEVSKII, transl. by A. CROZY. (Pp. 376. £5.) London: Pergamon Press. 1962.

This is a collection of forty-five articles covering a wide range of neurology and psychiatry. The majority of the papers are concerned with mental disorders associated with brain lesions. The approach is descriptive and the orientation rigidly organic. All mental disturbances associated with bronchial asthma are attributed to infections and toxins. There is an article entitled 'Role of external stimuli in the origin of hallucinations'. The author postulates that external stimuli must play a part in the origin of hallucinations, and one of his arguments is that 'dialectical materialism considers the psyche as a reflexion of reality'. One of the papers deals with neuroses and rehabilitation of the neurotics. The author expresses himself strongly against the admission of persons with hysterical blindness and deaf-muteness to the All-Russian Societies for the Blind and the Deaf and Dumb respectively. These neurotic conditions do not seem to be unusual, although the author asserts that 'the presence of neurosis in conditions of our Soviet reality is diminishing from year to year'. There is an interesting article about abnormal reactions of the autonomic nervous system in psychopaths but the interpretation of the results is unconvincing owing to the lack of control studies. The same criticism applies to studies on autonomic responses in schizophrenia and on the effects of sleep treatment. In a review entitled 'State and Tasks of Soviet child psychiatry' concern is expressed about the lack of research in problems of mental subnormality, learning disabilities and psychopathy. 'This is not surprising if we remember that Soviet child psychiatry has not been sufficiently sheltered over the last few decades from the negative influences of a whole number of erroneous and faulty conceptions— from the influence of pedology, the ideas of Kretschmer, Weissman, Morgan and Freud, "psychomorphology", etc.—which still even now

continue to serve as the "theoretical basis" of this discipline in a number of foreign countries.'

There is a short article presenting a 'physiological analysis of hysterical pseudology' which is believed to be due to the general weakness of the cortex. This conclusion is based on encephalograms which, in this country, would not be regarded as being outside the normal range. Uncharacteristic E.E.G. changes found in a case of cleptomania are thought to indicate the presence of 'organic lesion of the central nervous system with syndrome of compulsory desires in the form of cleptomania'.

It is unlikely that this collection of articles is truly representative of Soviet research today. They are extremely conventional and parochial. Most of them could have been written thirty or forty years ago. One can only hope that the thaw which has begun to permeate political relations between the Soviet Union and the Western world will soon spread into all fields of research.

E. STENGEL

Elements of Psychoanalysis. By Dr W. R. BION.

This book is intended primarily for practising psychoanalysts. Although only a little over a hundred pages long, the predominantly theoretical exposition and the original nature of the ideas presented may present difficulties for analysts not familiar with Dr Bion's views. In spite of this I regard this book as one of the most unique and stimulating contributions to psychoanalysis, in that for the first time a way is suggested of helping the analyst to clarify the nature of the analytic problems with which he is presented daily and to sharpen his own clinical intuition.

For this purpose the author suggests the use of a grid which can be used as a scanning instrument both for the patient's statements and the analyst's interpretations. This grid has two axes—one is vertical and genetic, and the other horizontal and describing the uses to which the patient's statements are being put.

The genetic axis describes the development of thought from the most primitive elements, which

can hardly be given even the status of thoughts (beta elements (row A)), through what he calls alpha elements (row B), which represent the conversion of the more primitive beta elements into those which can be stored and used for conversion into the next stage which are dream thoughts or myths (row C).

Rows D, E, F, G and H categorise successively preconception, conception, concept, scientific deductive systems and algebraic calculus in increasingly higher levels of sophistication of thought processes.

The horizontal axis contains six categories. These are: 1, definitive hypotheses; 2, statements or theories which are used to avoid the awareness of other theories which might produce a psychological upheaval; 3, 4, 5 and 6 relate to the functions of attention, notation, curiosity and action.

This grid is not to be used in actual sessions, but when the analyst thinks about his cases at the end of his day's work. Trying to place his patients' statements into a category which seems most nearly to fit in one of the categories on both axes of the grid and also doing the same to his interpretations, is believed by Bion to provide a valuable check on the accuracy of interpretations. Moreover, by playing 'the psychoanalytic game', in which although the analyst feels his interpretations were reasonably correct, he puts them into another category after the session and sees what the interpretation would then have been, the analyst is helped to widen the spectrum of his clinical acumen.

Bion also describes how preconceptions mate with realizations to form conceptions. A model of this would be the infant's expectation of a breast which when mated with a realization of a breast, forms the conception of a breast. Another model would be the preconception of a parental relationship which when mated with the realization would produce the conception of the parents. If attacks on the thinking apparatus are such as to prevent this conception being made, the patient never reaches the stage of having an oedipus complex in the accepted sense, with the result that oedipal problems can never be worked through, as happens with psychotic patients. In cases of this sort, the analyst's attention has to be directed to the factors leading to the fragmentation of the thinking apparatus.

In a short review of this kind, it is only possible to give a sketchy outline of the book but any

psychoanalyst who is interested in improving his own work and even deepening his self-analysis, is strongly urged to read it and if possible to try out the grid in his own work.   H. S. KLEIN

The Habitual Prisoner. By D. J. WEST. (25s.) Macmillan.

This book describes an inquiry by the Cambridge Institute of Criminology carried out by Dr D. J. West, Assistant Director of Research at the Institute. It is an account of the psychiatric investigation of 100 habitual prisoners, including 50 preventive detainees and 50 intermittent recidivists selected from Wandsworth Prison, the latter group showing substantial gaps in their criminal careers. The investigation was carried out by psychiatric interviews, home visist and/or interviews with relatives.

The most outstanding feature of this study is the large number of psychological deviants found in the series. From this point of view, the series is separated into the three categories of 'non-deviants', 'active-aggressives' and 'passive-inadequates'. Only 12% are found to be 'non-deviants', i.e. persons who, from the psychiatric and psychological viewpoint, are average personalities adjusted to a criminal subculture, this group including professional criminals. 36% were described as 'active-aggressive', this including those with the typical psychopathic traits of emotional indifference, lack of guilt feelings and a tendency to aggressive impulsive behaviour. Only a small number were in fact excessively violent in their behaviour. It is also interesting that very few prisoners in this group showed all of the generally accepted criteria of psychopathy. 52% were described as 'passive-inadequates'. In this group there was a high incidence of neurotic rather than psychopathic reaction and the group also included sexual disorders. In both the latter groups, social disorganization of all kinds was predominantly found. Also in this series of 100, there was a high incidence of actual psychiatric disability, either present at the time of examination or indicated in the earlier history, e.g. many had been in mental hospitals, or discharged from the Forces on psychiatric grounds. 12% were, or had been, psychotic and 16% showed other psychiatric abnormalities.

Of the intermittent recidivists, many had had a battery of psychological tests carried out, and the

most relevant of these were the M.P.I. and the M.M.P.I. As was to be expected, on the former high neurotic index was found, particularly among the 'passive-inadequates'. They also showed a higher introversion index than the 'active-aggressives' where extraversion rate was higher. The 'lie' scale and responses on the 'K' and 'F' scales of the M.M.P.I. were significantly high. Conditioning tests did not give significant scores to indicate that many of the group established conditioned responses abnormally easily.

The home backgrounds of the offenders showed very considerable variation, and by no means all came from a socially bad environment. There was, however, some correlation between a poor home environment and the less disturbed offender, while some of the more serious pathology was found in offenders from a better background.

While this study is of a series of 'habitual prisoners' not 'habitual offenders', the number of non-deviants is extremely low and raises the question of how this would compare with persistent offenders who are more successful and therefore not so persistently in prison. It does suggest that even in the latter group there would probably be found a high rate of psychological deviation. These findings cast doubt on the prevalently held sociological theories about the 'normality' of the offender group and the predominant aetiology of social and cultural factors. They also tend to shake the frequently held psychiatric view that persistent offenders are predominantly psychopaths.

Perhaps more important, as Dr West points out in his book, is the impact which findings of this kind should have on the whole concept of treatment and rehabilitation. Many of these offenders could in fact be treated in much more open conditions and Dr West refers to the success of Norman House, a London Hostel for ex-prisoners.

This is a very interesting book which should provide the basis for much further research into this field and there is a tremendous need for further individual socio-psychiatric studies of offenders. The text is well-illustrated, with case-histories, and this helps to overcome the slight confusion which the reader, particularly the psychiatric reader, may at first experience in relation to the descriptions used. The fact that the numerous statistical tables are all put together in an appendix to the main text also makes easier reading and continuity of the text itself.

KEITH R. H. WARDROP

A Practicum of Group Psychotherapy. By ASYA L. KADIS, JACK D. KRASNER, CHARLES WINICK and S. H. FOULKES. ($6.50.) New York and London: Hoeber Medical Division, Harper and Row.

This work is the result of collaboration between three members of the staff of the Group Psychotherapy Department, Post Graduate Centre for Psychotherapy in New York, and the president of a Group Analytical Society, London, and represents various viewpoints ranging from Adlerian to classical Freudian.

After the introduction and historical review, detailed instructions are provided for initiating a group. The problems of the institution or clinic in which groups are to be introduced are considered; the anxieties liable to be aroused in the existing hierarchy, and various ways of alleviating these anxieties, including a list of suitable films and tapes to aid staff understanding. Then the physical arrangement; chairs, time of day, length of session. Selection of patients is followed by an account of the hazards of the first group session and various group phenomena like acting out. Then different types of group, open or closed, therapy centred, authority denying and group centred groups; group therapy combined with individual therapy, therapy with clinical problems like alcoholism and psychosomatic disorders and the techniques of termination.

The book concludes with an interesting analysis of the academic background, geographical distribution, training and experience of the members of the American Group Psychotherapy Association and an account of the training available in group psychotherapy in America, a training following only after completed training in individual psychotherapy.

ENID CALDWELL

The Mental Patient comes Home. By HOWARD E. FREEMAN and OZZIE SIMMONS. New York: Wiley, 1963.

In recent years, in both Britain and America, there has been an upsurge of interest in community care for the mentally ill, and with it has come a realization that all too little is known about the experiences of psychiatric patients (or indeed about most other types of patient) after they leave hospital. This has prompted numerous research inquiries, on both sides of the Atlantic. Two groups of research workers have attained widespread

recognition both for the scale, and even more for the methodological rigour of their work in this field: these are the Social Psychiatry Research Unit at Maudsley Hospital, and the team in Boston whose work is reported in the present volume. Since 1955 the latter group, led first by Ozzie G. Simmons and later by his colleague Howard E. Freeman, have carried out a succession of studies of the post-hospital careers of mental patients. Their first study showed that parents appeared to tolerate the presence of patients still too greatly handicapped by their illness to be self-supporting; wives, on the other hand, demanded a higher level of social adequacy of their ex-patient spouses. In subsequent studies, the team has squeezed as much information as could be obtained from this type of inquiry, and yet they admit, in their penultimate chapter, to a certain disappointment over the limited predictive value of their social observations. The reason for this is not far to seek, because their team has consisted entirely of social scientists, with never a psychiatrist. Consequently, they have been unable to include data on the severity of the patients' clinical state, nor even to distinguish between manic-depressive and schizophrenic patients. The Maudsley group's studies have shown that these clinical characteristics are of vital importance in modifying the influence of social factors in the patient's environment. It is a measure of the authors' parochialism that, although aware of the existence of relevant British studies, their only references to this work relate to two partial reports which happened to be published in America. The neglect of essential clinical information imposes serious limitations upon these studies. This is all the more to be regretted because they demonstrate (with a very full description of their interview protocols and methodology) excellent models for empirical sociological research on a topic of considerable importance for contemporary psychiatric practice.   G. M. CARSTAIRS

The Perception of Causality. By A. MICHOTTE. Translated by T. R. and E. Miles. (Pp. 425. 45s.) London: Methuen and Co. 1963.

This is the first English translation of Michotte's report of his classic experimental studies of perceptual causality, originally published in France in 1946 as *La Perception de la Causalité*. Prof. Michotte has been well served by his translators who thoughtfully provide a useful chapter-by-

chapter summary of Michotte's experimental work, with their own comments which do much to clarify 'the logical moves by means of which Michotte develops his arguments'. As the main text contains the full details of over a hundred of Michotte's experiments, the commentary provided by the translators not only rescues the reader from reeling back in exhaustion, but allows him to follow the precise sequence of ideas which have led Michotte to his present theoretical position. Another undoubted advantage of this English translation is that it has allowed Michotte to add an Appendix in which he himself summarizes further extensions of his work and any revision in his ideas which have occurred in the intervening fifteen years since the book was first published. Michotte's basic position, that our impression of any causal event is based not on intuition or expectation but, on measurable spatio-temporal featurs of the stimuli themselves, is of obvious importance not only to the narrower field of perceptual causality, but to our thinking on the perception of reality as a whole. The strict behaviourist may object to the author's reliance on subjective reports of the objectively controlled phenomena, but such difficulties are discussed fully by Michotte.

The relevance of Michotte's experimental work to psychology of perception is considered by Prof. Oldfield in an admirable foreword, and Mr Miles also contributes two critical essays, one dealing with the relationship of phenomenology and scientific method, and the other with Hume's views on causality. To those working in the field of perception, this volume will of course have an immediate appeal, but it also provides to any reader a stimulating demonstration of the productive development of theoretical knowledge through a series of closely-knit scientific experiments.   ANDREW MCGHIE

Aspects of Psychiatric Research. Edited by D. RICHTER, J. M. TANNER, LORD TAYLOR and O. L. ZANGWILL. (Pp. 445.) London: Oxford University Press. 1962.

This book has been prepared by the Mental Health Research Fund to mark the tenth anniversary of its activities. It does this worthily; it is a valuable compendium of recent psychiatric research in this country and the quality of the chapters by the book's twenty contributors is very well sustained.

The book, of course, not only reports progress made in different areas of research, but mirrors British psychiatry's strengths and weaknesses at the present time. Where it has been possible to apply new techniques of investigation, progress has been impressive. Harris and Polani show in illuminating detail how advances in biochemistry and genetics have been used to reveal the aetiology of several types of subnormality and to demonstrate that prevention, specific treatment and cure are now more than possibilities in this long-neglected field. Tizard in his survey of the treatment of the mentally subnormal deals also with their education, training and rehabilitation, and properly complains of how little research is being done in the psychological and social aspects of this huge medical problem. 'In England and Wales the number of full-time research psychologists engaged in these problems is three.'

Some progress, reported by Marthe Vogt, Smythies, Crammer and Elithorn, has also been made in understanding the aetiology and physical concomitants of the so-called functional psychoses, and the mechanisms and effects of their treatment by drugs and convulsive therapy. The E.E.G. and epilepsy are reviewed by Bates and Pond. Freeman reporting disorders of attention and perception in schizophrenia demonstrates both a psychoanalyst's sensitivity and acuteness in eliciting clinical data and the value of psychoanalytic hypotheses in providing a basis for fruitful clinical and experimental investigations.

Epidemiological methods and findings to which British psychiatrists have made notable contributions are examined by Hare. Gibbens charts the slow development of the scientific approach to criminology and the psychiatrist's still modest research contribution, while Harrington has the unenviable task of gleaning the largely barren field of industry. Bowlby's argumentative and stimulating chapter on bereavement and psychiatric illness is the only article from child psychiatry, which is evidently still in the doldrums.

I. R. C. BATCHELOR

Trends in the Mental Health Services. A Symposium edited by HUGH FREEMAN and JAMES FARNDALE. (Pp. 333. 70s.) Oxford: Pergamon Press.

This book is not just another compendium. It brings together many of the most significant articles to date in the broad field of social psychiatry as envisaged under the new Mental Health Act. In addition, the editors are to be complimented in the quality and nature of the special articles which have been written for this book. The material has been divided into three sections, dealing with psychiatric hospitals, day hospitals, and community services. This is very balanced fare and current issues such as the vexed question of psychiatric units in general hospitals as opposed to separate mental hospitals, are dealt with in a very comprehensive way. Dr Maddison indulges in an amusing and interesting creative fantasy when he describes a psychiatric hospital in the year 1999. Dr D. G. McKerracher, Professor of Psychiatry at the University of Saskatchewan, gives an interesting account of his views about the possibility of the future general practitioner being trained so that he can deal with most of the clinical problems which arise in the field of psychiatry. Dr Russell Barton makes a plea for teaching in psychiatry to be less centralized in the teaching hospitals. However, he would not seem to go far enough and if some of the plans at present envisaged for total mental health services in the community are to be implemented it is clear that much of the teaching will have to be centred on the mental hospitals rather than on the teaching hospitals. James Farndale points out that one of the advantages of day hospitals is that they tend to attract good staff and have a wider appeal than the mental hospital with its traditional associations. But surely this is merely another indication that mental hospitals will have to come to play a much more central part in training and share more in the general interest of psychiatric work if they are to attract staff of high quality. Dr T. J. Boag describes what amounts to a therapeutic community practised in a day hospital. There is a fascinating account by Dr J. Tizard on the residential care of mentally handicapped children which serves to remind us what gaps there still are in the mere practice of institutional care and the remarkable effects that better organization and training can have on the well-being of inmates. Well placed towards the end there are two very valuable chapters on research which serve to counterbalance many of the exciting but unverified speculations which abound in the preceding chapters. G. F. Rehin and Dr F. M. Martin give an admirable survey of the problems which have to be tackled by research methods

before we can answer many of the current questions which must be raised by any competent local authority before they can know what is required of them in relation to staffing and psychiatric care generally. Dr Jacqueline Grad and Dr Peter Sainsbury give a fascinating account of their early researches in an attempt to evaluate some of the comparative results between patients admitted to mental hospitals for treatment and those treated in the community. They touch on current issues such as the possible harmful effect on the family when a psychotic patient is treated in the home. However, we must await more long-term research before they can give us any clear indication about the possible effects on the mental health of the children. Prof. Titmuss, in a penetrating article 'Community Care—Fact or Fiction', reminds us of the pitfalls in over-enthusiasm of an uncritical kind: 'At present we are drifting into a situation in which by shifting the emphasis from the institution to the community—a trend which in principle and with qualifications we applaud—we are transferring the care of the mentally ill from trained staff to untrained or ill equipped staff or no staff at all.' For people working in the mental health field in Britain, or for that matter in other countries, this book is an invaluable source of information and inspiration. MAXWELL S. JONES

The Psychoanalytic Study of Society. Vol. II. Edited by MUENSTERBERGER and AXELRAD. New York: International Universities Press. 1962.

This volume contains a most interesting collection of papers under the three broad headings of 'Childhood and Development', 'Art', and 'Anthropology and Folklore'.

There is a great deal to recommend in the book. The reviewer was particularly attracted to the three papers referred to below. The paper by Arthur H. Schmale, Jr., 'Needs, Gratifications, and the Vicissitudes of the Self-Representation: A developmental Concept of Psychic Object Relationships' is original at times in the author's approach to this subject.

The paper by George R. Krupp, 'The Bereavement Reaction: a Special Case of Separation Anxiety, Sociocultural Considerations', is a thoughtful study centred upon adult bereavement in contemporary America. The author shows how each culture has stabilized patterns for the handling

of loss. He considers a number of problems of universal importance, including the individual's reaction to bereavement and its different roots, the function of the funeral rites, etc. This paper received the 1960 annual award given by the Alexander Gralnick Foundation.

To recommend the book further, it contains a posthumously edited paper by Geza Roheim, 'The Western Tribes of Central Australia: Childhood'. This paper is to appear as a chapter in a book containing Roheim's as yet unpublished field report from the Aranda, Lurittya and Pitjentara. It is not possible here to do justice to this important collection of observations by the leader of psychoanalytic anthropologists. But some idea of its claim on our interest is given by the following quotation, which is fully supported by the material presented:

'We can characterize Central Australian Culture as one in which phantasies come closer to realization, in which the borderline between thought and deed is narrower.'

In short, this book is highly recommended reading for psychoanalysts and for those in related fields who have a special interest in the field of applied psychoanalysis. DR NAGERA

Family Ill Health. By ROBERT KELLNER. (Pp. xi + 112. 20s.) London: Tavistock. 1963.

The general practitioner is uniquely placed to observe the disturbed relationships that can both produce and result from illness in the family group. By occupying a central role in the drama, however, his value as an objective witness is correspondingly reduced. Dr Kellner, a G.P. from the industrial north, clearly understands and does not attempt to oversimplify this problem. This book commences with the account of a series of carefully documented cases in which the author illustrates the presence of family interaction in illness by pairs or clusters of entries recorded on a chart designed to include the whole family. Entered on such charts are most surgery consultations and house calls. The influence of one member of the family on another is strikingly demonstrated in cases of infrequent attenders at the surgery who make their first appearance there when illness affects a close relative.

Having made his point, however, the author inclines to the view that the so-called 'spread of

ill health' is more apparent than real. Coincidence infection, convenience and habit all contribute to the resulting paired and clustered entries.

According to Dr Kellner, illness in one member of the family, often serves only to render the others more 'doctor conscious'.

A basic weakness of the book which the author does not attempt to conceal is the arbitrary distinction drawn between 'neurotic' and 'non-neurotic' individuals. Perhaps, for the purposes of research, one of the well-known personality inventories could have been utilized in the attempt to differentiate between neurotic and normal patients.

Despite its relatively unsophisticated approach, however, or perhaps because of it, the book provides useful insight into family behaviour in illness.

L. H. COWAN

Research in Psychotherapy. Vol. II. Ed. by H. H. STRUPP and L. LUBORSKY. (Proceedings of the Second Conference on Research in Psychotherapy held at Chapel Hill, N. Carolina in May 1961.) (Pp. 342. $3.50.) Washington, D.C.: American Psychological Association.

This book consists of the proceedings of a second conference on research in psychotherapy, held three years after that reported by Rubinstein & Parloff (eds.) (1959, *Research in Psychotherapy*). It contains papers on a wide spectrum of recent studies in America, under three headings: the psychotherapist's contribution; measuring personality change; and the definition and study of significant variables. Contributors include psychoanalysts (e.g. Colby), psychiatrists working with schizophrenics (Barbara Betz), analytically oriented psychologists (Strupp, Luborsky), and psychologists studying conditioning therapy (Krasner) and client-centred therapy (John M. Butler).

A common factor is the determination to study these subjects as objectively as possible. The intellectual thinking, the objectivity and open-mindedness, and the degree of communication between workers of widely different outlook, are of a very high order.

At first glance, however, this book seems to be yet another example of objectivity and clinical usefulness being mutually exclusive. Though this does apply to the majority of the papers, I think it does not apply to three of them: (1) that by Betz on tests for discovering therapists likely to succeed with schizophrenics; (2) the Menninger study (Luborsky) which suggests that a high initial anxiety in the patient is an indication of good prognosis, and in which the author clearly realizes and discusses the fact that the situation cannot really be as simple as this; and (3) the paper by Siegal and Rosen, also from the Menninger Clinic, in which there is some extraordinarily clear thinking on the concept of anxiety tolerance. It is encouraging that even three such papers can be found among the welter of trivial or clinically fallacious results usually obtained by workers with this kind of objective outlook.

D. H. MALAN

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The relation of the ego to the self

By MICHAEL FORDHAM

INTRODUCTION

In this paper I shall consider only those parts of the subject which have been of particular interest to me. I can only express my regret to those who, thinking other parts essential, feel I have done violence to their conceptions. The paper is divided into three sections: the first enumerates some of the many efforts made to build a concept of the self based on empirical data; the second discusses the relation of the self to the ego; the third suggests ways in which the concepts developed can be used to elucidate analytic practice.

Since radically different data are being observed which are supposed to represent a single concept or entity I have paid attention to some varying methods used to obtain the data, only, however, entering into those methodological details relevant to the rather general style of presentation.

I. SOME DEFINITIONS

In his *Principles of Psychology* William James devotes a chapter to 'Consciousness of the Self'. There he considers the subject at length in the light of philosophers' deliberations and then current psychological knowledge. Much of what he says has naturally dated, but his general thesis is found amongst us today. In masterly fashion he ranges over a wide field to define the varying selves—now material, now social, now spiritual—amongst which we live. In this changing scene there is an overriding self, expressed in the sense of continuity of being and of personal identity. This he can call 'the pure ego', a change in terminology which caused him no trouble.

Since then the term 'self' has taken on

rather different but contiguous usages. When hypostatized, it means an entity which organizes separate parts of the personality into a whole and is the embodied personality, psyche and soma. Becoming aware of it is the goal of a particular life and, because every life is different from any other, the individual alone can become conscious of its unique characteristics. For this reason no true assertion can be made by a second person about another self (sometimes called true self) and accurate knowledge of it is outside empirical observation.

All this need not, however, prevent ideas being developed about the self so long as they are recognized as approximations, nor does it obstruct analysts acting as if the ideas were true. Thus the behaviour of analysts regularly accords with the assumption that they cannot decide what is ultimately right or wrong for any particular patient. Expressed anthropomorphically, they work on the principle that the self alone knows what is right for the individual.

Winnicott's (1958) use of the terms true and false selves seems in line with this thinking; a true self represents the real nature of a person and can be experienced by him in the way he lives. If I understand him rightly, the true self does not need analytic dissection and is therefore an irreducible datum.

Clifford Scott's (1949) concept of the body scheme also belongs to this area of study. He defined an entity which covers the total picture of the cosmic and personal situation of man as follows (1949, p. 142): 'Let us assume there is a more or less conscious integrate of sensations, perceptions, conceptions, affects, memories and images of the body from its surface to the depths and of the body from its surface to the limits of the

cosmos. Let us assume that it is an integrate that is concerned not only with what is inside a boundary but also with what is outside a boundary as well as with the boundary itself. ...This integrate is a scheme, or to use an old English word, a plan; and as the boundary or interface has not a peripheral but a central position, for our purposes, perhaps, it can best be called a body scheme.'

He instances a patient who called the scheme 'my enigma' (*ibid.* pp. 142–3): 'He was [35 years old and] reared a Roman Catholic. At 25 he had lost his soul and had felt better. He felt he could call his experiences either mental or physical. At 30 he ceased to feel any essential difference between body and mind. He felt an improvement in his ability to deal with work, children and adults. What he had in place of mind, body and soul he called "my enigma"—the enigma of growth and development. His growth is continuing.'

The patient's account introduces 'growth and development'. Scott makes explicit the cosmic element frequently found in writings on the self. To exemplify it, he cites a number of disciplines in which he conceives the body scheme to be relevant: embryology, neurology, academic psychology, parapsychology, religion, psychiatry, psychoanalysis and poetry. I am sure he could have added more.

Jung's empirical research

In a series of papers and books Jung advanced the study of the self in a way which is close to Winnicott's empirical writing about a true self. His conclusions are also like Scott's in that the self is a scheme, with a centre, a boundary and a cosmic dimension; it also embraces the psyche-soma and remains ultimately an enigma. Jung, however, claims more than either Scott or Winnicott. He not only formulated ideas about the self but studied empirically how the self could be made conscious. With this aim in view he observed patients in whom symbolic images, which took the form of configurations, or

structures, referred clearly to a single totality. The images have symmetrical characteristics expressed in terms of numbers or geometrical forms. They have a well-defined boundary, a central point round which a number of elements may rotate, and are frequently divided into four compartments or are organized in terms of four objects. The mandala symbols to which this description refers are the best documented evidence, though other imagery can refer to the self; indeed, Jung finally sums up the position by stating: 'Anything that man postulates as being a greater totality than himself [the ego] can become a symbol of the self' (Jung, 1948, p. 156).

In some sense the symbols express states of integration or wholeness and summarize the degree to which unconscious affects have been integrated.*

In addition to his clinical data, extracted from dreams or active imagination (1944, 1959; and others), Jung also studied ethnological parallels in large numbers and accumulated a formidable mass of evidence in support of his thesis.

Others, for instance, Adler (1961), Baynes (1940), Harding (1947), Wickes (1938), have confirmed Jung's observations, whilst Perry (1953, 1957, 1962) has shown that self images can be found in the hallucinations and delusions of recovering psychotic patients. It remained for me (Fordham, 1944, 1957) to show that the images could be found in the dreams and fantasies of children and that they were related to ego growth.

Jung's method of eliciting data

Since Jung's formulations are abstractions derived from his empirical observations we can neither estimate their reliability nor evaluate them without being clear about the method he employed to elicit his data.

* The affects are classified into those that have either been split off in the course of development or have always been unintegrated and never before made conscious.

He studied dream sequences and extracted recurrent archetypal themes from them. Alternatively, he used active imagination (Jung, 1916; also Fordham, 1958), which we can now consider in more detail.

Active imagination is a method which builds on the capacity of patients, usually of middle age, and showing rather marked schizoid or depressive trends, to treat their inner world objectively. An object is deliberately imagined; it may be painted or modelled but, in whatever medium it be expressed, the aim is to establish an inner subject–object relationship. If proceeded with consistently, the method leads to individuation, a progression recorded by a sequence of symbolic images and changes in the attitude of consciousness (cf. Fordham, 1958 a). The attitude which Jung aimed to induce by using active imagination is close to that described by Kris in terms of a 'good analytic hour'.

In the 'good analytic hour' the ego regresses and at the same time observes till the analyst 'can put what he has to offer into a question and the patient himself can do the summing up; the patient's participation is thus maximized' (Kris, 1956, pp. 451 f.). Continuing, Kris says: 'The principle involved is, I believe, fairly stated when we say that when interpretations are offered, the controlling part of the ego over the state of temporary and partial regression, is expected to expand into an observing one.' He proposes that 'The object of this observation is the *self*'!*

All this occurs within the inter-personal setting of the psychoanalytic set-up and differs from Jung's attempt to initiate a method in which such observation was made by the individual in isolation (cf. Fordham, 1963). My object in taking an example from the experience of a psychoanalyst is to show that

* Though Kris does not refer to anything like the symbolic material which Jung details, Aigrisse (1962) shows that mandala symbols can be found in a case treated along psychoanalytic lines. She saw her patient twice a week and analysed childhood memories using free association.

different methods can interdigitate. Whilst strictly speaking results cannot be separated from the method of attaining them, yet it is of particular interest if comparable observations can be made using different methods.

Kris gives us a warning about the pitfalls of self observation; it 'may become symptomatic of obsessional scrupulosity or narcissistic introspection "the self admiration of the mirror image"...but [self] observation as autonomous function tinged as it may be by both self critical and self loving components, is essentially characterized by its detachment, or, as one might say, by the individual's ability to achieve objectivity in his perceptions about himself. It is a goal never to be reached...but...at least a tendency towards detachment may be all important' (*ibid.* p. 452).

It has been made a reproach that Jung's method leads to both the faults mentioned by Kris and, indeed, some of the literature displays them. All that need be said here is that, if his methods of observing dream and fantasy opened the door to obsessional scrupulosity or narcissistic preoccupation, these are not results which Jung himself would have agreed to countenance except as transitory states of mind.*

Besides these dangers there are, I think, others which need consideration because of Jung's contention that he is studying objective data which cannot be assimilated by the ego under the conditions he set up.

(1) It could be that his methods increase tendencies to depersonalization and that consequently the objects are not fundamentally objective but are the result of their alienation by the ego (cf. Federn, 1953).

(2) The method may foster splitting in the ego or even ego disintegration.

It is known that active imagination can occasionally precipitate psychotic reactions, but the cases in which this happens invariably show evidence of a previous or a latent

* I believe this is true even though Jung's concept of narcissism would differ from that found in psychoanalysis.

psychosis. That Jung's case material often gives a rather dissociated picture is largely due to his method of extracting archetypal contents from the material as a whole. So as to avoid confusion he explicitly says that he deliberately leaves out all personal matter (Jung, 1944, p. 42). In the actual treatment of patients this is impossible and is only justified by his special interest. Against these supposed defects, the well-selected cases, representing samples from a large number of others, show clearly how his method helps to harness the potential in the unconscious. The archetypal forms, therefore, make it possible to integrate the energy, whether previously dissociated or never before integrated, in manageable quantities (cf. Fordham, 1951). With reference to the unintegrated elements, Jung considers that the development resulting from their integration is only possible with the help of his psychological technique, which consequently represents an historical innovation.

Characteristic of Jung's work is the combination of clinical observations with ethnological parallels. Jung elucidates the historical dimension* in the following way: he defines the more stable components in the inner world by finding out which recur and which do not. Then he relates the recurring themes to their historical parallels and thus his clinical data are set in a matrix of historical antecedents. Combining this dimension with his emphasis on prospective on-going developments in time, it is easy to account for his interest in the sophisticated complex structures which his data show. They contrast sharply with the simpler object relations revealed by analytic reduction of these structures to their origins in infancy and childhood. It may be necessary to point out here that partly because of his on-going, prospective interest, Jung's studies are not analytic in any sense of the term which is meaningful and were not intended to be so. He repeatedly insisted that he aims to study

* Lambert (1962) brought this out well in his recent paper.

the synthetic processes in the psyche (cf. Jung, 1953; and others).

It was to implement this aim that he limited the analyst's influence by reducing the frequency of interviews (Jung, 1935, p. 20) and diminishing his interpretative efforts as well. Both procedures were intended to increase the patient's active interest in the parts of himself that can be treated objectively and handled individually with minimal assistance from anybody else.

His demarcation between synthetic and analytic treatment is, however, not so convincing today as it was when he first elaborated it and cannot be maintained with the rigidity sometimes implied, for instance by the idea that therapy can be divided up into two parts: the first being reductive, the second being synthetic. Further his procedure is not so different in principle from contemporary 'psychoanalytic' techniques of interpretation as it was believed to be at first. He aimed, for instance, to reduce anxiety by linking up the experiences with comparable ones recorded by other people and introduced educational methods, such as selected reading and seminars, so as to give information about the imagery which becomes conscious and which is otherwise confusing. He recommended myths and religious ritual—as used either today or in the past—so as to show the patient that he is not alone in his experience and that others have survived it. In principle this is also an aim of interpretations which differ, however, in being intentionally made more personal by including the transference.*

As it may be supposed that these reflexions detract somewhat from Jung's work, I want to leave no doubt as to my own position. I

* An interpretation implies that the analyst has experienced in the past, and is now able to manage, something like the patient's present experience and which the patient fears that he cannot survive. There are clearly great differences between education, learning and interpretation but there may well be an untapped field of study by comparing the two procedures more carefully.

consider Jung was the first to evolve a method whereby the self could be systematically observed and experienced.

Jung's two definitions of the self

There are two incompatible concepts of the self running side by side in Jung's writings (cf. Fordham, 1963). One definition states that the self is the *totality of the psyche* comprising the ego, the repressed personal components of it, and the archetypes: another idea is that the self is the *central archetype*, i.e. one amongst a number of dynamic structures within the total self, having the special function of bringing order into the plurality of archetypes and of exerting a special influence over the ego as well.

The reason for his second definition seems to be that, in the course of his work, Jung had collected observations showing that the self images could be projected, introjected, could inflate the ego by becoming identified with it, etc. It is therefore obvious that the empirical self could not possibly be conceived as the whole of the psyche but must represent states of partial integration. The concept of the self as an archetype thus accords much better with available data than with the idea of it as a psycho-somatic totality.*

Integration and deintegration

There are two features of Jung's material which have been of particular interest to me:

(1) Though the data show an inner consistency, their content varies greatly: anything from a small dot to elaborate structure will do to represent the archetype of the self and only when a reasonable degree of organization has taken place do the symbols show

characteristics referred to above (p. 90). They thus represent states of organization or steady states which are more or less conscious.*

(2) The integrated states shown by the symbols are periodic.

What is going on in between the steady states and how and what dynamic process makes it possible for their content to vary by increasing in complexity? These two questions suggest that the self concept needs revision along the lines that I first put forward some years back (cf. Fordham, 1955). There I outlined an idea that only one function of the self is to organize and integrate; it also divides itself up spontaneously, and for this event I proposed the term deintegration. Thus I introduced a new view of the subject: the self is no longer conceived as a static structure, instead the steady state represents one phase in a dynamic sequence: integration is followed by deintegration, which in turn leads to a new integrate. The sequence is conceived to repeat throughout life and lies at the root of maturational development.

In formulating this process theory, I had also in mind the tendency of integrated stable states to be sterile in that they could not allow adequately for the incorporation of new components. I was confirmed in this idea by the studies of creative activity undertaken by Marion Milner in her book *On Not Being Able to Paint*, and in Ehrenzweig's paper 'Creative Surrender'. Both contained ideas which came close to what I was wanting to present.

II. EGO AND SELF

Quite early on in his career Jung defined the ego as the centre of consciousness. This conception was part of his theory of complexes which rested on experimental evidence (cf. Jung, 1906–9).

In his later empirical work, particularly when using active imagination, he found it

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* Cf. Fordham (1963) for an attempt to solve the quandary of the two definitions from within the frame of reference provided by analytical psychology.

* They can occur when the subject feels whole or quite the reverse, as in some forms of catatonic schizophrenia (cf. Perry, 1957).

essential to distinguish the ego from the archetypes because of the need to keep the archetypal experience objective and so avoid inflation of the ego. He therefore underlined his definition, repeatedly and sometimes emphatically, by asserting that the self is different from the ego in that it included unconscious processes which the ego did not. Keeping as close as possible to his empirical observation, he also thought of the ego as a subjective personal datum in contrast to the objective archetypes and the self.

In this context it is possible to understand his assertion that the self 'is completely outside the personal sphere' (Jung, 1951 a, p. 30); a statement, however, that also combines happily with his interest in the study of those religious experiences which have social, historical, and anthropological implications.

However, as his work developed his ideas changed. He discovered that some of the archetypal forms, particularly the shadow, contained ego structures which had been split off and needed re-assimilating into the ego. Later he went further and recognized an unconscious aspect to the ego; indeed, in the *Mysterium Coniunctionis* (1956, p. 117)—his last important book—he developed a basically different concept of the ego. It is phenomenologically identical with the self and, since the self is a union of conscious and unconscious components, the ego must be made up of these two elements also. Here then, the concept of the ego has got deepened, but all the same he still maintained that the self was to be distinguished from the ego, rather in the sense that god (the self) made man (the ego) in his own image.

Jung demonstrated a synthetic process in the personality reflected in symbolic forms: he described his method clearly and demonstrated his results, but his account of the relation between personal and archetypal experience is unclear or lacking (cf. Fordham, 1963a; Williams, 1963). This led me to study the work of psychoanalysts to see whether they could help to fill in the gap Jung had left.

We have already referred to the work of Winnicott and Scott, but Federn's struck me as the more relevant for the purpose I had in mind.

Jung, it will be remembered, approached the subject of the self from the study of schizophrenia. Federn (1953) also investigated the same realm and had become a psychoanalyst after starting as a psychiatrist. He studied the empirical sense of 'Ich Gefühl' which is translated as 'ego feeling' or 'self feeling'. In these investigations the ego concept was more comprehensive than that with which Jung had begun but like his later formulation.

Nothing resembling active imagination is found in Federn's studies and it seems that he had not thought of the symbolism found in schizophrenia as therapeutic in any sense that Jung meant it or in any sense that Perry (1957) developed. Federn was consistently in favour of preventing the manifest schizophrenic disorder by reinforcing the ego against the disease process. Therefore he concentrated his interest on ego boundaries and the relation of these to depersonalization and estrangement (also called derealization). This makes a link with observations by analytical psychologists in that it is recognized that as the archetypes emerge into consciousness—and especially the central archetype of the self—feelings of strangeness or mystery are registered. Federn, however, emphasized their negative meaning and investigated them in terms of narcissistic cathexes as the psychoanalytic metapsychology required: an advance on Jung's thesis because it is more dynamic and explanatory; a retreat because there was no room for the concept of a central archetype which seems to be of value when studying the psychoses.

It may be tempting to consider Jung's observations on the self in terms of splitting in the ego and do away with the necessity for operating with two entities. To do so it must be shown that a concept of the self is unnecessary. It has been shown above that, on empirical grounds, there is much against

such a solution. If Jung's and Federn's work be compared, that conclusion is reinforced. Federn distinguishes two kinds of estrangement, that applying to external and that applying to internal objects, but he develops his observations and ideas only in relation to the former. This ties in with his negative evaluation of the symbolism in schizophrenia and there is little doubt that he devalues the inner world in the terms it is studied by analytical psychologists in such detail.*

It is no surprise to find that Federn ended up in the meta-psychology of ego cathexes and the subjects of primary and secondary narcissism. If we accept the idea that theories can represent archetypal forms (cf. Fordham, 1958 c, 1963), it then seems probable that, in his theories, he was unwittingly representing the inner processes under consideration. The form was abstract and so the value of the imagery behind it eluded him.†

Relevant interest in ego psychology was recently expanded and with it seems to have come an interest of a self which is different from the ego. Hartmann (1950) was one of the psycho-analysts to distinguish between the two. He states: '...in using the term narcissism, two different sets of opposites often seem to be fused into one. The one refers to the self (one's own person) in contradistinction to the object, the second to the ego (as a psychical system) in contrast to other substructures of the personality. However, the opposite of object cathexis is not ego cathexis, but cathexis of one's own person, that is, self cathexis...'. He thus began to differentiate the self from the ego and others have followed him. It is, no doubt, on the basis of this work that Sandler (1962) defines

a self schema having the following characteristics:

(*a*) it is not the same as the ego;

(*b*) it contains conscious and unconcious components;

(*c*) it has a shape which can appear in the representational world and can change;

(*d*) the shape gets built up gradually.

These characteristics are close to, but not I think identical with, the ideas I am putting forward on the basis of Jung's thesis. They evidently throw a different aspect into relief in that they study how the self representation gets built up.* Spiegel (1959) worked on this by introducing theories based on experimental data, an approach also used by R. D. Scott (1956) and reported in a difficult but stimulating paper in which the work of neurologists, and in particular that of Henry Head on the body scheme, is made use of.†

Spiegel thinks that the idea of pooling perceptual data can be brought in and says (p. 96): 'In the beginning of mental life, separate states of tension and discharge succeed each other, such as hunger, thirst, diffuse sexual tension, bowel-bladder tension; these leave traces in the form of mental representations; the pooling function establishes an average representation of each separate representation of these states which, as a result, possess permanence and continuity in time....In the normal individual these average representations become interconnected and grow into a steady frame of reference to which we give the name self.' Whereas he considers that the pooling process is a function of the ego alone, it may also be contributed to by the functioning of archetypes in the unconscious. These may be conceived to order and arrange perceptual

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* Presumably because it is believed to contain so much preconscious matter and considerable secondary elaboration.

† I am fully aware that Federn's defect has been made up for by other psychoanalysts such as Klein, whose work is therefore relevant, but Federn came nearer to formulating a psychology of the self.

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* Hoffer (1949) puts forward a fascinating idea that the earliest representation of the self occurs in the equation between hand and mouth. He suggests that the equation has a neurological basis.

† Scott also suggests making a distinction between the body scheme and body image.

data on average lines rather as the gestalt psychologists propose.*

To conclude this part of my thesis, it is clear that a number of research workers agree that, though they may not know very well what the self is, they have yet ways to define it in terms of clinical or experimental data. All of them discuss the relation of the ego to the self. I have assumed that they all refer to the self as a single entity. It would also be possible to develop the alternative thesis that several contiguous entities are being referred to.

III. Analytic observations

Approaching the self from Jung's standpoint I have become interested in applying his ideas and observations to analytic practice so as to include personal components and development from infancy onwards. Jung paid little attention to either of these and I have tried to supplement his work by applying his thesis to observations made in the transference setting. Instead of looking at the problem in terms of symbolic imagery reported by the patient, it is my object to define data which can be directly observed. In passing we may note that Jung (1946) himself had included the transference in his studies of the self and its manifestations, but he had done so mainly in terms of alchemy and of the structure of society.

Regression

An influential factor in what I have to say now has been the positive attitude which Jung sometimes adopted to regression. He went so far as to state (1930, p. 33) that: 'The regressive tendency only means that the patient is seeking *himself*...'. This statement combined with his essay on 'The Child Archetype', especially in the section 'The

* It may be of interest here that Spiegel draws on the work of Helson, who suggests 'a neurological model to account for pooling' (Spiegel, p. 96, n. 7). Jung (1958, pp. 370 f.) also considers that the self, as central archetype, has a neurological basis.

Child as Beginning and End' (1957, pp. 117 f.), suggested to me that one object of regression could be to realize steady states noted in discussing the self conceived as the central archetype.

It is not at all difficult to find examples of steady states: the 'good analytic hour' described by Kris is one, but his description is incomplete so I will supplement it. After, or during, a good piece of analytic work there is frequently a favourable change in a patient. Matters which had earlier been the object of intense anxiety get talked about as shades of their former selves. Memories from childhood change so that aspects of a parent come to light which had before been uncommunicated or denied. The patient himself seems more self contained and able to relate to his analyst, to have an identity of his own and at the same time boundaries become firmer and more resilient. When it first appears, this state is almost certain to be unstable and will give clear indications of the lines future disintegration will take. But when the steady state occurs, particularly in the analysis of psychotic parts of the personality, it is a significant event because, once it has been achieved, and the patient retains a memory of having felt whole, later disintegrations are likely to be more easy to handle.

Steady states often depend upon reaching, through regression, an affective balance which the patient can manage. Thus material presented in terms of oedipal patterns, with a great deal of persecutory anxiety and idealization, can become relatively unimportant when a further regression is made to a two body relationship. The oedipal conflict has not been resolved, it has been abandoned by regressing from the genital to the oral phase in which the object relations are less complex, become positive because of a preponderance of good over bad objects. It is a stage in development which has been relatively successful and so makes a good point of departure for dealing with bad objects.*

* It will be evident that these steady states of relative wholeness are different from fixation points.

States of wholeness may occur with nobody else present. Jung, I suggest, may have found a non-analytic way to make these truly worth while because he showed his patients how to be with themselves, alone, within a closed system, and find it productive.

States of wholeness also occur with one other person present. Then a relationship is possible if the second person is also stable enough. Once this has been achieved the infant or patient can go on to manage three or four body relationships. Once a four body set up has become possible (self, mother, father and one sibling) it is usually assumed that other more complex object relations will present relatively little difficulty. Today, however, research suggests that a group is more than a family and introduces different conflict situations.

If some self realization, and so a relationship, has become possible, then analysis is possible; when achieved, quite a lot can be done about less developed states in which the patient needs to be alone (and a unit) so long as the analyst is willing to be treated as non-existent.

Dimensions of ego and the self

Reading Federn's book with Jung's thesis in mind did not fill in the gap between personal and archetypal experience as I had hoped.* It became increasingly clear, however, that two dimensions were involved; that of the ego and that of the self. If the 'Ich Gefühl' be considered from the dimension added by the self concept, then it would be conceived as manifesting the central archetype in the ego. I now want to approach the subject of the two dimensions from a different angle by considering further the subject of regression.

When Little published her thesis 'On Basic

* Instead I began to suspect that 'personal' meant something different in psychoanalysis from Jung's idea of it. Possibly person in psychoanalysis corresponds more closely to self than personal in Jung's writings.

Unity' she described the management of regression to a state of fusion with the analyst, a state to which the patient needed to regress and had to be accepted. Her paper was followed by another in which the authors, Nacht & Vidermann (1960), asserted that regression to this state should be firmly controlled, since it led to abandonment of the ego in favour of fusion with the analyst. Here were two attitudes towards regression to a state of unity through fusion. They seem, at first, incompatible but they can be seen in terms of the two dimensions under consideration.

To eludicate further what is meant by the two dimensions reflected in the two papers, I want to introduce the postulate of a primary integrate or original state of the self first suggested by me in 1955. It corresponds to the state of Scott's patient (see above, p. 90) in that there is no relevant distinction between mind and body. In order to derive psychic structure from the integrate I assumed that it deintegrates; when the first deintegration occurs was left an open question. However, in view of increasing knowledge about intra-uterine life it certainly happens before birth. The flood of stimuli provided by birth itself and the release of breathing, crying activities producing anxiety must certainly be an early deintegrative state. It is assumed that the infant reintegrates again before he starts his first feed, in which instinctual release (deintegration) occurs.

The primary integrate is, subjectively, a phenomenonless state. I have applied this idea to some schizophrenic children by assuming that basically they are so integrated as to be inaccessible. Their inability to express themselves is primary and so is conceived to depend upon a hard core of the personality which cannot be reached, there being no means with which to express what is there; i.e. it has not deintegrated.

Daring as this idea may seem, I can illustrate it by the example of a schizophrenic child which must be a frequent experience to others. He never made much improvement

over a period of several years. I kept in touch with him for 10 years. To my recurring surprise he always insisted on coming to see me, but never said a word. I could only with confidence say that what I said or did had any influence twice. On each occasion it was dramatic and due to an interpretation: one stopped him getting fevers, another made it possible for him to relax and look at me directly with love.

It may be thought that he had successfully preserved his good objects inside him against me and that I represented an overwhelmingly dangerous persecutor, but there was little evidence for that hypothesis and a true inability to express himself was much more likely.

An adult patient, who nearly died of a severe illness many years before she had started analysis, stated that she felt her emptiness at the time of her illness was full of a power without form, so she could not express anything.* She had told me of a state that I infer lay at the root of the child's pathological stability.

Long ago Kant postulated a transcendental ego which William James discusses and quotes from Kant as follows (p. 362): 'At the basis of our knowledge of ourselves there lies only "the simple and utterly empty idea: I; of which we can not even say we have a notion".' Substituting self for 'I' reaches what I have in mind: an original self integrates without phenomena. It is first manifest in infancy and persists to be represented in philosophy and religion, for instance in the oriental doctrine of maya.†

The original phenomenon-less self is assumed to develop by deintegration—instinctual release is one clear manifestation of it—and this leads to a primary identity with the mother‡ which first occurs in the

early stages of breast feeding: the original integrate being reflected in oral identity with the breast.

The essence of deintegration is thus part of a progression brought about through the breaking down of integrates and dissolving previously established unities. It follows that in normal development the state of primary identity—or unity—with the mother is transitory and inevitably breaks down, leading* to the formation of a new integrate, a new dynamic equilibrium within the child himself corresponding to, but more differentiated than, the original self unity. It is a development in the sense that part of the original self has become ego.

Returning to the dramatically different attitudes adopted on the one hand by Little and on the other by Nacht & Vidermann. It is clear that, conceived in terms of ego psychology, primary identity can only give opportunities for the ego to abandon all that has been established later (this is the position of Nacht & Vidermann, 1960). Looked at from the dimension of the self, a different attitude is possible towards regression to fusion with the analyst-mother. If the primary identity† with the mother is a development, an early deintegration, it is an on-going

altogether satisfactory and I suggest that primary identity is better.

* I assume good enough mothering.

† Basic unity and primary identity are here taken to be synonymous. Little follows Winnicott in conceiving basic unity with the mother as a primary state. In her summary she says (1960a, p. 637): 'Within an individual both survival and the ability to find objects with which relationships can be formed depend upon the existence of a unity which comes from the entity mother-infant (or analyst-analysand). From it a rhythm of differentiation and reassimilation or integration comes. It provides the "stillness at the centre" which allows of movement and perception; it is the *sine qua non* for living continuously in one's body, for having an identity, and for being identical with, and able to make assertion or statement of, oneself.'

* This adult patient was using words not available to her at the time of her experience.

† Namely, that the phenomenal world is a sort of creative illusion that can ultimately be dispensed with.

‡ Neither the terms basic unity nor primitive identity as used in analytical psychology are

process, a step forward and the model for deintegration in general. This conception accords with Little's findings and attitude about the need for some cases to regress to 'basic unity' with the analyst.

If primary identity with the mother has never been reached, then there is nothing that can be done analytically. If it has been achieved and everything following is precariously balanced, then it will be necessary to regress to the state of primary identity before the processes of growth and development can proceed satisfactorily, but it will mean the analyst being ready to feel treated as non-existent in the sense of being a delusion. Since some schizophrenic children have got far enough to let analysts function as parts of themselves in this sense, it may be assumed that primary identity with the mother has been achieved by some of them. That explains why they are accessible if given forms (interpretations) which they use increasingly to express themselves. However, this method modifies classical psychoanalysis and brings in the need for something like education.*

Counter-transference

In an earlier paper published in this journal I stated that the self 'controls and has controlled all my thinking about counter-transference' (Fordham, 1960 b, p. 6). I would now like to record some notes amplifying what I then meant. My statement was made with the following idea in mind: to conduct analysis on the basis of a theory and its corresponding technique fails to describe adequately how an analyst works.

In terms of the self the situation between analyst and patient consists in the interaction between two personalities. The analyst's theory and technique must therefore express, in generalized form, that part of himself

* Compare above, p. 92. It is assumed that an interpretation acts as an object (mother–analyst) with which the child fuses, and then uses it to 'learn' about himself.

which is put in the service of the patient, and in particular his past experiences which he has discovered how to manage. Theory is understood, not as an autonomous impersonal structure upon which the analyst bases his technique, but as the abstract expression of the analyst's own self in so far as he relates to his patients as a whole.

From this position it is apparent why the analyst must be analysed while he learns analytic method: only thus can acquired technique be firmly related, at every point, to the analyst's emotional capacity and his personal experience reaching into the self.

According to this idea, teaching techniques and theories of analysis rely upon the common archetypal basis of the human personality, and upon the like nature of the structures that have been built upon it through identifications made in the course of development. However, there are also the individual characteristics of the self to be considered: these ensure that any theory of analysis or psycho-therapy is an incomplete statement, and represents the common pooling of experience with the individual characteristics shorn off it. In analysis itself the individual characteristics are reinstated.

This formulation may look like theoretical nihilism and could lead to the idea that each analyst will develop his own unique theory and technique. This is roughly speaking true in that general theory has to be modified with each patient, but if the archetypal structure of the personality be made conscious it will be possible to recognize the generalities in the special theory devised to fit each patient. Then the individual theory will contribute decisively to generalized theory.

So far these ideas are an interpretation of accepted ideas current in analytical psychology based on Jung's concept of the dialectical process. What does the idea of the self as a deintegrating and integrating system add? It implies that the process of analysing a patient depends upon the analyst having gone through a sufficient number of integrated and deintegrated states to reduce his anxiety

to manageable proportions about changes occurring in the self.

An illusional or delusional counter-transference (Fordham, 1960a) depends not on deintegration of the self but on disintegration in the ego. By contrast: in a satisfactory analysis without an illusory counter-transference, a transitory regression will occur when an analyst puts an unconscious part of himself in the service of the patient. If the self deintegrates, there is no necessity for splitting in the ego so long as the self is distinguished from the ego. The term syntonic counter-transference differentiates this state of affairs from the illusory counter-transference. The syntonic counter-transference depends on the self boundaries dissolving without the ego disintegrating; then deintegration will be followed by integration. The ego, distinguished from the self, is enriched and strengthened in the process without its boundaries being seriously disturbed. Under these circumstances the ego acts as a recording apparatus for unconscious states and as the instrument which can communicate them to the patient.

This conclusion accords with the clinical experience that it is safe for a normal projection by the analyst to enter into the patient or for the analyst to introject parts of the patient. Each will be respectively withdrawn or ejected again later on, without the analyst needing to exert the kind of control which is associated with conscious processes (cf. Fordham, 1960; Money-Kyrle, 1956).* It may also be added here that these processes are effective because a good analyst will inevitably link his interpretations with his own affective processes, so making it possible for him to participate in the affect of his patients without danger to himself.

In my view the processes described above are illustrated by a frequent sequence of events which occur in training analysts. A new candidate may start off with apparent

* I recognize that this formulation does not take sufficiently into account the idea of the ego becoming the mirror image of the self.

confidence only to find, with the help of his supervisor and analyst, that his interpretations are off the mark and reveal fantasies relevant, not to his patient, but to his own psyche. They thus reveal an illusory counter-transference—the result of splitting in his ego. There follows a period of disillusionment and depression in which the candidate becomes excessively cautious. Finally, he regains his confidence by discovering that he can gradually rely more and more upon his responses to his patient without exerting conscious control. This time, when projection and introjection occur, the result is on the mark, reliable and a true expression of that part of the self which can be used in analysing patients. The candidate gets much more free in his work and can 'let himself go' in a way that was also possible at the beginning and which needed to be regained. Now, however, since he is no longer producing illusions, interpretations become increasingly accurate. At the same time he becomes much more able to take in and digest his supervisor's ideas and comments adapting it to his own style of analysis.

Therapeutic results

To conclude I would like to refer to the subject of therapeutic results, whose estimation seems so elusive. It is disconcerting that the individual characteristic of the self puts all estimates of its dynamic activity outside generalization, and make all estimates of therapeutic results approximate for ever. I do not think, however, that this conclusion need deter us from ignoring the individual component until it makes general statements manifestly absurd.

Suppose, then, we grant that the self is a general frame of reference to which results can be referred. As a dynamic system we would have to include stability and instability as necessary variables. Normality, currently defined as a steady state, can no longer be treated as a criterion by which to estimate a satisfactory therapeutic result; on the contrary any assessment would have to include

the capacity of a patient to negotiate abnormal as well as normal states (cf. Fordham, 1960). Only making longitudinal assessments in time satisfies this more exacting requirement. A cross-section assessment giving the state of a patient at any particular time must be insufficient.

SUMMARY

There is growing recognition of the need for a term which refers to the whole psyche-soma: self, real self, body scheme have been mentioned. Attempts to define it are being made and Jung claims to have put it on an empirical foundation. He distinguishes the ego from the self. A similar distinction is being made by psychoanalysts approaching it from a different direction. Comparing the studies of Jung and Federn suggests that ego psychology and self psychology can be thought of in terms of different dimensions expressed by Jung in a dichotomy between personal and archetypal components.

Jung's data show periodic states of integra-tion or steady states; they show boundaries and their content varies, but there is usually a high degree of complexity and organiza-tion. Since the steady states are periodic and change in content, it is assumed that the integrates can lose their boundaries and deintegrate. This introduces process theory; i.e. the self is conceived as not only a dynamic and stable structure but also as an integrating-deintegrating system.

Considering how self theory applies to analytic procedure, to regression and to counter-transference, it is suggested that there is an original state of the self, an integrate without subjectively definable con-tent. This deintegrates so that a delusional perception of unity with the mother, corres-ponding to the original unity, becomes possible as part of a developmental process. This is described as primary identity to which regression can be necessary in analysis. The regression can only be viewed negatively from the dimension of ego psychology but becomes positive when viewed from the dimension of the self.

REFERENCES

ADLER, G. (1961). *The Living Symbol*. London: Routledge.

AIGRISSE, G. (1962). Character re-education and professional re-adaptation of a man aged forty-five. *J. Analyt. Psychol*. **7**, 2.

BAYNES, H. G. (1940). *Mythology of the Soul*. London: Routledge.

EHRENZWEIG, A. (1957). Creative surrender. *The American Imago*, **14**, 3.

FEDERN, P. (1953). *Ego, Psychology and the Psychoses*. London: Imago.

FORDHAM, M. (1944). *The Life of Childhood*. London: Routledge.

FORDHAM, M. (1951). The concept of the objective psyche. In *The Objective Psyche*. London: Routledge, 1958.

FORDHAM, M. (1955). The origins of the ego in childhood. In *New Developments in Analytical Psychology*. London: Routledge, 1957.

FORDHAM, M. (1957). Some observations on the self and ego in childhood. *New Developments in Analytical Psychology*. London: Routledge.

FORDHAM, M. (1958a). Individuation and ego development. In *The Objective Psyche*. London: Routledge.

FORDHAM, M. (1958b). Problems of active imagination. In *The Objective Psyche*. London: Routledge.

FORDHAM, M. (1958c). The development and status of Jung's researches. In *The Objective Psyche*. London: Routledge.

FORDHAM, M. (1960a). Counter-transference. *Brit. J. Med. Psychol*. **33**, 1.

FORDHAM, M. (1960b). Ego, self and mental health. *Brit. J. Med. Psychol*. **33**, 4.

FORDHAM, M. (1963). The empirical foundation and theories of the self in Jung's works. *J. Analyt. Psychol*. **8**, 1.

HARDING, E. (1947). *Psychic Energy*. New York: Pantheon.

HARTMANN, H. (1950). Comments on the psycho-analytic theory of the ego. *The Psycho-analytic Study of the Child*, **5**. London: Imago.

HOFFER, W. (1949). Mouth, hand and ego integration. *The Psychoanalytic Study of the Child*, 3–4.

JAMES, W. (1950). *The Principals of Psychology*, 1. Dover Publications. London: Constable.

JUNG, C. G. (1906–9). *Diagnostische Assoziations-studien*, 1 and 2. Leipzig: Barth. Trans. by M. D. Eder as *Studies in Word Association*. London: Heinemann. New York: Moffat Yard, 1918.

JUNG, C. G. (1916). Transcendent function. In *Coll. Works*, 9, i.

JUNG, C. G. (1930). Some aspects of modern psychotherapy. In *Coll. Works*, 16.

JUNG, C. G. (1935). Principles of practical psychotherapy. In *Coll. Works*, 16.

JUNG, C. G. (1944). Psychology and alchemy. In *Coll. Works*, 12.

JUNG, C. G. (1946). Psychology of the transference. In *Coll. Works*, 16.

JUNG, C. G. (1948). A psychological approach to the dogma of the Trinity. In *Coll. Works*, 11.

JUNG, C. G. (1951a). The psychology of the child archetype. In *Coll. Works*, 9, i.

JUNG, C. G. (1951b). Aion. In *Coll. Works*, 9, ii.

JUNG, C. G. (1953). Two essays on analytical psychology. In *Coll. Works*, 7.

JUNG, C. G. (1956). *Mysterium Coniunctionis*, 1. Zurich, Rascher.

JUNG, C. G. (1958). Schizophrenia. In *Coll. Works*, 3. London: Routledge.

JUNG, C. G. (1959). A study in the process of individuation. In *Coll. Works*, 9, i. London: Routledge. New York: Pantheon.

KRIS, E. (1956). On self observation. *Int. J. Psycho-Anal.* 37, 6.

LAMBERT, K. (1962). Jung's later work: historical studies. *Brit. J. Med. Psychol.* 35, 3.

LITTLE, M. (1960a). On basic unity. *Int. J. Psycho-Anal.* 41, 4, 5.

LITTLE, M. (1960b). On basic unity. *Int. J. Psycho-Anal.* 41, 6.

MILNER, Marion (1957). *On Not Being Able to Paint*. London: Heinemann.

MONEY-KYRLE, R. E. (1956). Normal counter transference and some of its deviations. *Int. J. Psycho-Anal.* 37, 4, 5.

NACHT, S. & VIDERMANN, S. (1960). The pre-object universe in the transference situation. *Int. J. Psycho-Anal.* 41, 4, 5.

PERRY, J. W. (1953). *The Self in Psychotic Process.* Berkely and Los Angeles: University of California Press.

PERRY, J. W. (1957). Acute catatonic schizophrenia. *J. Analyt. Psychol.* 2, 2.

PERRY, J. W. (1962). Reconstitutive Processes in the Psychopathology of the Self. *Ann. N. Y. Acad. Sci.*

SANDLER, J. (1962). Psychology and psycho-analysis. *Brit. J. Med. Psychol.* 35, 2.

SCOTT, R. D. (1956). Notes on the body image and schema. *J. Analyt. Psychol.* 1, 2.

SCOTT, W. Clifford M. (1949). The body scheme in psycho-therapy. *Brit. J. Med. Psychol.* 22, 3, 4.

SPIEGEL, L. A. (1959). The self perception. In *The Psycho-analytic Study of the Child*, 14. London: Imago.

WICKES, F. G. (1938). *Inner World of Man.* New York: Toronto.

WILLIAMS, M. (1963). The indivisibility of the personal and collective unconscious. *J. Analyt. Psychol.* 8, 1.

WINNICOTT, D. W. (1958). *Collected Papers.* London: Tavistock.

The libido plethora syndrome: a clinical study

By MORTIMER OSTOW*

How do the antipsychotic drugs achieve their therapeutic effect upon disturbed psychic function? I have proposed (1962) that they alter the amount of libidinal energy available to the ego; specifically that the monoamine oxidase inhibitors and iminodibenzyl derivatives increase the ego's libido content and that reserpine and the phenothiazine tranquilizers decrease it. Using these theoretical assumptions and observations of the effects of drug administration, I have been able to delineate the role of fluctuations in ego libido in the pathogenesis of mental illness and in symptom formation.

Briefly, it is my impression that when the initial phase of conflict is not resolved by symptom formation in the classical manner, libido tends to accumulate in the ego and to rise to pathologic levels. As it does so, it induces specific alterations of ego function, some of which, when they become extreme, constitute symptoms of another sort—that is, symptoms which derive from a libido plethora within the ego. This plethora is permitted to grow only up to a certain point. In some individuals libido is never permitted to rise beyond normal levels; in others it may rapidly reach pathological values. In each case, sooner or later, a threshold is reached, or a dynamic trigger is tripped, whereupon the plethora is dissipated by a process of depletion. Thereafter the symptoms of the illness consist mainly of attempts to combat this depletion, or, of manifestations of libido deficiency.

In any given patient and in any given episode of illness, the phase of plethora may be brief or protracted; it may be arrested at its beginning or it may be permitted to evolve to a grossly abnormal state. Generally,

though, the phase of plethora is confined to a relatively brief interval at the beginning of the illness. During the major part of the illness the patient is occupied with the neurotic or psychotic effort to combat depletion, or with the suffering of actual deficiency. In the case of some patients, during a number of years, there is an alternation of states of mild plethora and mild depletion resistance.

Obviously clear-cut clinical descriptions of the various energy states that I have assessed will make this theory more useful and more credible. Therefore I have made a study of the actual plethora states that I have seen. The first phase of pathogenesis, which consists of conflict and symptom formation without significant deviation of ego libido, is generally the most elusive of the various phases and is the one which the psychiatrist is least apt to see. The plethora phase too is seldom encountered by the psychiatrist except when an excited patient is brought into a hospital against his will. In a state of plethora, patients seldom appeal for assistance. Most of our clinical experience deals with depletion and deficiency states.

Accordingly almost all of the plethora states I have encountered which are sufficiently clear-cut for study are those which I have myself induced by giving energizing drugs. It is these, therefore, which I have studied. This series comprises two grossly and seriously schizophrenic patients who were hospitalized, and ten neurotic or ambulatory psychotic patients. Finally, I shall compare the manifestations of plethora seen among these patients with the phenomena encountered in a patient who recovered from melancholia into hypomania after a year of analysis without medication.

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In order to facilitate description, I have selected several categories of psychic function. Let us first consider ego function apart from the gratification of instinctual demands or defence against them—the function, that is, of what I have called the ego supplement.

Almost all of the patients become aware of a sense of vigour, of energy, of good feeling. It may express itself in positive terms:

'I have energy.'

'I feel better.'

'I feel peppy.'

'I feel very energetic and work tirelessly around the house.'

'I'm in full action. My mind is clear and I'm my old self.'

It may also express itself in negative terms:

'The sense of shame and guilt are gone.'

At some point the awareness of being driven becomes ego alien.

'I have the feeling of being driven to do work, but without the will to do it. I'm doing things though I'm exhausted.'

'I feel keyed up.'

'I think this is a high. I'm as active as I was in early years.'

Some patients display an overtalkativeness leading to a telltale hoarseness, and they write many long discursive letters. 'My arm is tired,' said one, 'but this letter will go quickly.' Another wrote, 'Forgive me for not rewriting this letter—I was writing letters almost all day and feel too tired.'

As the libido level rises still further, it becomes clear that the ego functions are driven too hard and suffer.

'There's a funny mental alertness that's scary to me.'

'I've been laughing and talking incessantly,' said a young woman, who went on to report that she was neglecting her education. 'But studying is like sleeping with a corpse.'

'It's a strange life I've been leading,' said a man (M.O.O.). 'I've been talking too much to the guys at the club. I understand that someone complained that I was aggressively butting in on conversations. I have ten calling cards of various people I've talked to in the

past week.' This patient, an alcoholic, used alcohol freely to combat his plethora discomfort, as he had used it before to combat his depletion discomfort. 'My whole system is vibrating and my ears are ringing. I'm jittery.'

With some patients, the industriousness to which they were driven was clearly excessive. They did hard physical work day and night. Often they remained awake and active during a major portion of the night.

As pressure increases further, the patient feels uncomfortable and becomes excited, belligerent, rambling and irritated. R.L.X. said, after the plethora was reduced, 'I've been to hell and back.'

The second area in which I found distinct alteration of function is increased erotism. Men speak of frequent erections and an increased tendency to masturbate. Morning erections are often noticed. The women mention increased 'sex feelings', amorous thoughts and desire.

But these sexual desires could seldom be satisfied with the patient's husband or wife. 'I wanted to kiss my husband,' said R.L.X., 'but I couldn't.' K.N.X. would be awake at night with amorous thoughts about men other than her husband.

The defence against this intensified erotic drive often impaired actual performance during intercourse and created symptoms. M.D.S. noted a 'numbing' of sexual sensation and a difficulty in achieving orgasm. M.O.O. observed the same interference with orgasm. The former, a man with many obsessions and compulsions, developed a new obsessive thought. He feared that by flicking an electric switch in some irregular manner, he might accidentally set a fire in his or someone else's home and cause great loss of life. I believe that this symptom represented an effort to displace his hypererotism from himself on to the objects who triggered his love. He hoped that it might consume them instead of him.

Since potency difficulties have been described as a toxic effect of energizing drugs,

we must consider the possibility that the symptomatic impairment I have been describing falls into the same category. Let me cite the following two facts as contrary evidence. First M.O.O. who found difficulty with orgasm during drug-induced plethora, told me that he had had similar difficulties in the past when he was taking no drug. Moreover, I have subsequently seen him in mild plethora not induced by drugs in which the same difficulty appeared. Second, C.E.P., whose recovery without drugs I shall present below, also described genital numbness with erection. I conclude therefore that impairment of sexual performance results from the libido plethora whether the latter is brought about by autochthonous psychic processes or by medication.

M.O.O. in state of plethora, developed a mild driving phobia. He became concerned about the possibility of accidents on the road, especially while driving to his sessions. The act of driving to the object became, by displacement, an erotic act. While driving he often developed erections, and once masturbated while driving.

K.N.X. felt that her clothes were too tight; her neck and shoulders were stiff; she complained of throbbing pains in her head. Her erotism was evidently displaced from her genitals to body structures.

Two attractive women, X.E.T. and R.L.X., described unpleasant fantasies affecting the face. The former imagined that she was torturing her face and felt no pain. 'I feel dirty,' she added, 'like a prostitute.' The latter told of dreams of ugly, mutilated faces. The face in each of these two women had assumed the significance of a genital organ, and, in a state of plethora, had received the genital's excess libido. Now, because it was too highly libidinized, it became an apparent source of pain and therefore the object of destructive instincts.

The third large area which we shall describe, is the area of object relations.

First, there was an obvious tendency to engage objects in erotic activities. M.D.S.

described, at one point, an impulse to kiss host and hostess upon leaving a party. Such an idea was most unusual in his conscious life; he ordinarily leaned over backwards to avoid outward display and even inner acknowledgement of affection. At another point, in a surge of pleasant excitement following a successful business transaction, he punched an associate. Punching a friend was an idea which had often occurred to him but he seldom permitted himself the liberty of doing so because he realized the erotism that was masked by the act of aggression.

Secondly, as we noted above, the drive toward love objects was seldom directed to familiar individuals, that is, members of the subject's family. There seemed to be a firm inhibition of love for husband, wife or parents.

One substitute for an erotic relation with a familiar object was simply a turning toward strange objects. R.L.X. could not kiss her own husband but gave serious thought to the possibility of an affair with casual acquaintances. K.N.X., while in bed with her husband, and even during intercourse with him, indulged in erotic thoughts about strangers. M.R.H. expressed contempt and pity for her husband, but love for her doctor, that is, her family doctor as well as her analyst.

The strange object might be a homosexual one. M.D.S. said that he was afraid to look at men for fear of being considered homosexual. At the same time, he thought it only proper that his wife and he not spend too much time together, so he insisted that they sit in different rooms each evening. His yearning for a homosexual object was so strong that he began to fear a fantasied nocturnal intruder.

M.O.O. stayed out of the house a good deal, and when he did come home, he listened to music through earphones (to isolate himself from his wife), and slept on the couch in the living room rather than share a bed with his wife. While away from home, he drank excessively and conducted long, intimate conversations with men he met at his club.

He would even sleep there at times. During the period of plethora, he planned a long summer vacation of travelling through Europe. When the drug was cut down sharply, the idea of travelling no longer appealed to him and he cancelled plans for the trip. Instead, he took his family to spend the summer with his parents at their summer home.

This displaced erotism led, not infrequently, to projections. X.E.T. feared that her girl friend was jealous when she spoke to the latter's fiancé. 'Why does everybody on the street look at me as though I were the sort of person they could make sexual advances to?'

Projections occurred especially frequently in the case of homosexual impulses. M.O.O. expressed a host of ideas concerning my sexual feelings about him. 'I'll bet you have homosexual drives of your own,' he said. 'I'd like to find imperfections in your sex life. I was tempted to listen in to your phone conversations on the waiting room telephone to find out about your sex life. I used to think that the psychoanalyst would throw a rope around my neck from behind and arrange to have me tortured to show me that I wouldn't enjoy experiencing my sex fantasies.' He imagined at times that the pills I prescribed were poisonous.

In a fine flourish of primary process, R.L.X. exclaimed, 'My husband is a homosexual—he has a woman on the side.' It was she who wished to have a girl friend, but projected her homosexuality upon her husband ignoring the inconvenient fact that if her husband had an affair with a woman, that would not make him a homosexual. She dreamed that she was feeding her girl friends out of a suitcase, with three eggs.

This estrangement between husband and wife seems fairly constantly to accompany recovery from depression. The partner who was not ill and who generally worked to sustain the patient and suffered his abuse during depression, finds to her dismay that when the patient recovers, he becomes disaffected, and ignores, abuses and deserts her.

There are two reasons for this phenomenon. First is the fact that in plethora, the partner who has become a familiar, and therefore an oedipal object, becomes intolerable, and must be replaced by a strange object. Second is the fact that in adult life, the neurotic process generally begins with disaffection between husband and wife. In the state of depletion hypermotivation, the patient clings to this object he had attempted to give up. When he recovers, though, he can no longer tolerate her.

One of the difficulties of this type of intensive research, as opposed to the extensive but superficial survey of large numbers of patients, is that one can not form a reliable impression of the frequency of the phenomena one observes. For example, it seems to me that in the state of plethora the libidinal object of both men and women is a man, while in the state of depletion clinging, the object is generally a woman. Therefore the object in plethora is homosexual for men and heterosexual for women. I realize, of course, that this generalization is not universally true. Some of the apparent exceptions represent instances in which the object, of whatever sex, acquires the characteristics of an original object of transference. Thus, in clinging hypermotivation, the male analyst as well as the female, may be assigned the role of mother. In plethora, the patient comes to see himself as mother, and the analyst becomes a contemporary erotic male object, rather than a female parent surrogate. This is only preliminary formulation and obviously requires further checking and considerable elaboration.

The withdrawal from erotic relations with familiar objects often expresses itself as some sort of detachment. The detachment may be physical—that is, the patient may attempt to put a spatial or temporal distance between himself and the object. In this category belongs M.O.O.'s absenting himself from his home, his isolation from his wife by stereophonic earphones, and his sleeping on the living room couch. R.L.X. would remain in

department stores until they closed, and then wander about the streets at night. The frequent staying awake at night serves not only to discharge excessive energies, but also facilitates the separation from the sleeping spouse and precludes the need to respond to sexual advances.

The detachment may also achieve expression as a psychic or affective disengagement. One young woman, R.M., paradoxically became depressed as she withdrew more and more from her family. When she saw other people enjoying companionship, she became envious. X.E.T. said, 'I can feel things more and wish I couldn't.' She too became envious when she saw others enjoying party conviviality and in desperation exclaimed, 'I wish the end of the world would come. It's hard to understand that it's necessary to go on living.' She was unmarried, and after spending a night visiting with a married friend, she vowed she would never again sleep over at the home of married friends. 'I have feelings,' she said. In this last instance we see the pain, anger and envy generated by unsatisfied longing and the consequent wish for detachment. Other patients simply stated that they felt detached.

Muscle cramps, and especially neck twisting and jaw clenching, described for example by K.N.X., represent aversion and detachment from love objects. This same tendency, carried still further in plethora induced schizophrenia, led to tense aversive catatonia in two of my patients. Here the detachment was served by the aversive neck twisting, eye closing, jaw clenching, and rigid resistance to contact or influence.

The relation to the analyst deserves a special word here. Whereas in depletion clinging, the image of the mother is usually transferred on to the analyst, and in states of libidinal normality, the image of the father, in plethora, as we noted above, the analyst generally appears as a contemporary lover rather than a parent surrogate. My women patients have expressed their appreciation, love and erotic desires fairly openly. Those men who could tolerate homosexual feelings acknowledged

their love. Those who could not, defended themselves by means of their own characteristic defences. One, M.G., found it necessary to leave on each of two occasions when drug-induced plethora succeeded melancholia. Such patients became especially eager to terminate the course of medication as soon as possible so that they might escape from this threatening relation.

On one occasion, R.M. wept when I left the room for a moment because she missed me. X.E.T. became convinced, when she failed to encounter my wife for a period of several weeks as she came into or left the house, that my wife had left me. This was evidently a delusional wish to possess me and get rid of my wife.

Not only is it true that when plethora succeeds actual deficiency or depletion clinging, the patient gives up his anaclitic relation to a mother surrogate; he actually identifies with this maternal object as he gives it up. In the case of a man, this identification involves seeing himself as a woman. M.D.S., whose wife was pregnant, imagined substituting a sample of his urine for hers. Both he and R.O. toyed with the fantasy that they possessed breasts.

In the case of women, the identification with mother involved the fantasy of being pregnant and of taking care of children. D.N.C., a catatonic schizophrenic, in plethora, placed a pillow under her clothes to pretend that she was pregnant. R.M., when her menses were delayed a few days, became seriously concerned about the possibility of being pregnant though she had not had intercourse since her last menstrual period. In other words, the fantasy of pregnancy based upon the wish, became sufficiently realistic to create anxiety despite the patient's knowledge that it was not possible. M.R.H., in a busybody fashion, began to interfere with a young mother in an effort to teach her to care for her new baby. R.L.X. became more attentive than usual, to her children, and reported the dream that she was feeding her girl friends with three eggs. X.E.T. began to reorganize her mother's

wardrobe and to purchase clothes for her, though there was no need to do so—the mother, quite competent herself, resented her daughter's interference. My patient worried about her mother as though her mother were her child, and deplored the silliness of her young contemporaries.

This tendency to identify with mother in plethora creates repercussions in transference. It was generally in a transference role of mother that the analyst presided over the patient's recovery from a state of deficiency or clinging depletion to the state of plethora. So it is not surprising that when he arrives in plethora the patient tends to identify with the analyst. R. O., a businessman, considered the idea of setting up a counselling agency for business executives. R. L. X., at a time when I was preparing to leave on vacation, dreamed of supervising some children at mealtime. The most drastic instance was provided by M. R. H. who, on arriving at the office one day, pleasantly urged me to lie on the couch while she would sit in my chair.

The identification with mother often expresses itself in generosity. Patients in plethora exhibit the generosity of manics. They become productive in an artistic way, writing, painting, sculpting, and they bring their productions in as gifts. In time they will offer to increase the analytic fee or to refer new patients.

Commonly they adopt a parental, protective attitude towards any likely candidate. M. O. O. himself a white Protestant, imagined defying his white Protestant neighbours by introducing negroes and Jews on to his property. R. O., who had a wife and adult son, considered starting a new family. M. R. H. devoted herself in a most extravagant way to entertaining some twenty adolescent guests of her children at an overnight party.

This identification with the omnipotent mother of childhood, taken together with the facilitation of all ego functions and the tendency toward a narcissistic retreat from meaningful object relations, leads to the sense of omnipotence and invulnerability which commonly characterizes the state of plethora.

Sleep is often disturbed in the state of plethora though I am unable to identify the essential change. Most patients find that they require considerably less sleep than they ordinarily do. They go to sleep late and awaken early. When the libido level rises sufficiently, they may work through the night. In a state of mild or moderate plethora though, patients who in deficiency could not sleep, find their sleep improved. It is noteworthy that no matter how little the patient sleeps, he does not complain.

Several of my patients reported an improvement in appetite, but this seemed to be more a relief from the anorexia of deficiency, than a specific manifestation of plethora. The bulimia of depletion hypermotivation did not occur.

More characteristic of the passage from deficiency to plethora than of the plethora state itself, is the rebirth fantasy. The latter is not associated specifically with this or any other energetic phenomenon. It quite commonly accompanies remission of any pathologic condition. So that it is seen as frequently upon recovery from plethora as it is upon recovery from deficiency. M. D. S. recollected, during one session, as an association to telling me of his gratitude to me, that when he was 10 years old, he witnessed the rescue of survivors of a shipwreck. Rebirth was also expressed in a number of instances as a pregnancy fantasy which I have illustrated above.

The consistency of the syndrome I have described among this group of a dozen patients suggests that it actually exists and is not merely a collection of random conditions. But the possibility remains that it is not a naturally occurring condition but an artifact of treatment with anti-depressant drugs. I assume that the drug-induced state reproduces a natural state, both characterized by an excess of genital libidinal energies. In order to ascertain how closely the syndrome I have described corresponds to the spontaneous

condition. I have reviewed the case of a patient who recovered from a melancholic depression and passed into a hypomania while under analytic scrutiny and without the assistance of drugs.

C. E. P., after a year of daily analysis, spoke of feeling better for the first time on 5 November 1949. During the next few days, though he retained his improvement, he noted some anxiety and 'jitters' especially at night, and after the light was turned out. On one of these nights, he dreamed that 'a cat was sitting up—an Egyptian cat. It had had no food for two days. I gave it water first and then milk.' The starving cat was obviously himself (and his penis), no longer recumbent but arising. He now reached out for emotional as well as caloric nourishment, both of which he had been rejecting during the past 2 years. But nocturnal anxiety and craving for nourishment do not seem to characterize the plethora state as we have described it. Both are seen in anti-depletion clinging. Perhaps in the process of recovery from deficiency to plethora, the patient may traverse for a short period, a state of anti-depletion clinging. In my most recent experience with drug-induced plethora (R. O.), momentary nocturnal anxiety did appear for 2 days at the beginning of recovery from libido deficiency.

On 12 November, C. E. P. was feeling definitely better and had decided that he wanted to become a psychiatrist, an idea hitherto foreign to him. Here we see the identification with the analyst in the interest of caring for others who were sick. A few days later he acknowledged an awareness of increased affection for me. At about the same time he described a growing resentment against his wife. He had been estranged from her for several years before this most recent of several periods of depression, but in the few months before recovery he had attempted reconciliation and accepted her efforts to comfort him. Now with the return of libido, he again found her intolerable and turned to strangers for love.

On the night of 14 November, he attempted intercourse with a girl friend. Erectile potency was definitely improved but numbness impaired his performance and enjoyment. That night he slept badly and awakened early with a sense of depression. Here we see the impairment of genital performance similar to that which some of my patients in the drug series described. The reader will recall that we did not know how much of the difficulty to attribute directly to drug effect, and how much represented dynamic defence against excessive libidinal drive. In this instance only the latter can have been effective. We see also that the automatic withdrawal even from the new love object threatened to reprecipitate his illness; just as being jilted by another girl had initiated it.

Nevertheless, his recovery held and his sense of euphoria grew. At times he said he felt half-drunk. He resumed carving, which he did well. In dreams we saw the rise of homosexual fantasies and desires which created transference difficulties. He was aware of some amnesia and thought blocking, more marked during his sessions. These probably represented efforts to deal with unwelcome impulses by denial and repression. His dreams revealed Oedipal concerns with fear of punishment by castration for stealing from father.

With the need to retreat from both heterosexual and homosexual objects, we find an intensification of narcissism. My patient described a sense of freedom and power in his carving. He felt as if he wanted to float, to fly, to challenge Hitler. He expressed the desire to possess the mental powers of a genius, to combine male and female in himself.

Toward the beginning of December, there were days in which clinging seemed more prevalent than plethora confidence. He began to give me his carvings, thereby expressing his plethora generosity, and the gratitude and seductiveness necessitated by recurrent threats of depletion.

I think that we may fairly infer from this case that the phenomena which we encountered in drug-induced plethora appeared also in this instance of libido plethora which occurred under psychoanalytic influence alone. It is likely then that the two states are identical though initiated differently.

To conclude, let me summarize our findings. The state of genital libido plethora can be described in terms of ego characteristics and drive characteristics. Among ego characteristics we can list the following:

(1) a sense of vigour, energy, euphoria;
(2) a feeling of being driven;
(3) overactivity and overtalkativeness;
(4) impairment of mental activity;

(5) insomnia;

(6) excitement, irritability and belligerence.

Drives were affected in the following ways:

(7) increased genital erotism;

(8) impairment of genital performance;

(9) evocation of symptoms which attempted to deal with the excessive erotic excitement; these symptoms might be psychotic (manic, paranoid or catatonic) or neurotic (hysterical, phobic or obsessive-compulsive); they were often hypochondriac;

(10) increased pursuit of love objects;

(11) a preference for the strange over the familiar object;

(12) a preference for homosexual objects, expecially among men;

(13) defence against object drive by detachment;

(14) change in the nature of the transference: the analyst loses his parental role and becomes a contemporary lover or an object of protective concern;

(15) a tendency on the part of both men and women to identify with the mother;

(16) fantasies of pregnancy and desires to create and to give;

(17) narcissism leading to feelings of omnipotence.

REFERENCE

Ostow, M. (1962). *Drugs in Psychoanalysis and Psychotherapy*. New York: Basic Books Inc.

A methodological approach to the problem of obsessional neurosis*

By J. O. WISDOM†

I. INTRODUCTION

There would be some excuse for thinking that hysteria was fairly thoroughly understood. What is the position about obsessional neurosis? The close study of it goes back nearly as far, but probably most analysts would claim no more than that it is moderately well understood. Many discoveries have been made about its content and wide variety of manifestations, and there are some foundation stones for an explanatory theory, but even a clear, detailed, and reasonably complete diagnostic theory has never been formulated. Thus there is a most extensive knowledge of the phenomena but the theory is in an undeveloped state. The immediate task is to get existing knowledge into perspective and then to develop the theory. Metascientific procedures may be usefully employed to sift the syndrome, diagnostic factors, and so far as it goes the explanatory theory, and thus to reveal what the main problems are. Many questions are deliberately left aside, e.g. the role of trauma or the relation to the Oedipus complex, because they have only a secondary relevance to questions of mental mechanism; moreover, in tackling the theory of obsessional neurosis, it is necessary to construct a reasonably full statement of what that theory is before one can begin to consider the question of evidence for it, and this question will not be considered here. Attention is restricted exclusively to basic mental mechanisms.

* Elaborated from one part of a paper given to the Imago Group, London, 10 November 1959. The present investigation is similar to a previous one carried out on hysteria (Wisdom, 1961).
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II. SYNDROME AND CLASSICAL VIEWS

The syndrome may be summarized thus:

(i) obsessional‡ actions and obsessional thoughts;

(ii) compulsive‡ actions and compulsive thoughts;

(iii) compulsion to repeat;

(iv) ritualistic attitude;

which are ostensibly non-personal; and

(v) hate; impaired capacity to love (Abraham, 1911, 1924; Jones, 1923);

(vi) sadism;

(vii) masochism;

‡ The difference, if any, between the use of 'obsessional' and 'compulsive' in the literature is not definite. Here an arbitrary distinction is introduced for purposes of clarity: 'obsessional' for the aspect of an action or thought containing a wish, and 'compulsive' for the aspect that aims at counteracting the obsession. There are, of course, pure examples of thoughts or actions containing solely a wish and of thoughts or actions aiming solely at counteracting the obsession, but usually the manifest symptom is a combination or compromise-formation.

Obsession and compulsion in this sense share the general characteristics of pre-occupation and unavoidability. The essential difference in the common use of language is that 'compulsive' stresses what cannot be avoided and 'obsessional' stresses pre-occupation. The present use, if not wholly in accord with the common meaning of the words, does not depart far from it. In psychoanalytic literature generally, my impression is that the use of the two terms is for the most part in agreement with the use here suggested, but is not very consistent (even the exact opposite, 'compulsive' for wishes and 'obsessional' for defences can be found).

(viii) sharp ambivalence;

(ix) admonishing* attitude;

which involve personal relations.

I have deliberately added ritualism and admonishment to the syndrome on the grounds of being characteristic (and to a marked extent, though they are not wholly peculiar to the disorder). Apart from this there would be no real dispute, though some would make the syndrome more elaborate by including more remote effects.

Basic in this connexion is Freud's theory of the anal phase, which, however, was a theory of both normal and abnormal development. According to it, the infant puts a high valuation on faeces and anal erotism, but suffers disappointment about them. The explanation of this is crucial and will be discussed in a further paper. The infant has various ways of meeting his disappointment: the normal processes leading to substitute interests, and the abnormal leading to 'anal fixation', which refers to persistence of valuation of faeces and of anal erotism. But we must be more exact here about the scope of the concept. According to the development aspect of the theory, some of the valuation and erotism becomes transformed by reaction-formation and sublimation, most is deflected from the anal zone to the genitalia (how this may happen is another matter), but some normally remains untouched. When in abnormal states some of the deflected valuation and erotism becomes recentred on the anal zone, i.e. there is regression, the subject is said to be 'fixated' at that zone. This means that he has never really given up his interest and valuation, so that they reassert themselves at any suitable opportunity. Now the residue that normally is never deflected should, for clarity of conceptualization, not be included in what is fixated; in other words, it is best to keep 'fixation' for what can be deflected. The concept could be used differently; there is no

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* Later content will show roughly what 'ritualistic' and 'admonishing' refer to; for brevity I omit an account.

scientific right or wrong about it, but this usage is convenient, and enables us to regard fixation as abnormal. This use also has the advantage of ruling out any possibility there might be for holding that reaction-formation and sublimation, because of stemming from the anal phase, presuppose fixation. We may summarize thus: there is in infancy first a high valuation of faeces and of anal erotism, then dissatisfaction is experienced in connexion with them; this leads normally to devaluation of faeces and of anal erotism by reaction-formations and sublimations, and abnormally to 'anal fixation', which consists of unrelinquished valuation of faeces and anal erotism.

Freud's diagnostic theory may be said to consist of the following factors:

(a) anal fixation, involving both faeces and anal erotism (Freud, 1909, 1913, 1918);

(b) omnipotence of thoughts (Freud, 1909);

(c) latent passive homosexuality (Freud, 1918);

(d) regression from the Oedipus situation understood in phallic terms (Freud, 1918);

(e) isolation of affect (Freud, 1909, 1918);

(f) psychical undoing of current actions and thoughts (Freud, 1909).

On these Freud laid great stress; and he did commit himself in regarding anal fixation as characteristic (Freud, 1913).

It is not at all obvious how all this is to be put together to explain the disorder. I will therefore attempt to reconstruct, or rather construct, the classical psychopathology, in a form such as Freud might have given if he had worked his ideas out systematically.

III. THE CLASSICAL PSYCHOPATHOLOGY OF OBSESSIONAL NEUROSIS

The following is offered as a construction in terms of Freud's ideas. (References are practically out of the question even for the statements Freud obviously would endorse, and impossible for those I have put together

in order to complete the picture.) First symptom-formation:

(i) Faeces and anal erotism arouse distress (the explanation of this is obscure and will be discussed in a subsequent paper);

(ii) to obviate this, defecatory activities undergo displacement;

(iii) the sense of omnipotence is an anal derivative, developed from the sense of power in creating and excreting faeces;

(iv) displacements of defecatory activities carry the sense of omnipotence with them; some of these are *obsessional acts* and *thoughts*;

(v) the affect of defecatory activities and the affect to do with faeces are left behind (hence we get a sort of sublimation with no object); this is what the *fixation* consists of; the mechanism of separating affect and activity is known as the defence-mechanism of *isolating*;

(vi) the fixation is aroused by regression from failure to adjust to or to progress to the Oedipus situation at the phallic level;

(vii) thus there arise activities that are endowed with omnipotence but lacking affect about an object; such activities conceal their origin and thus control or prevent—this is their function—the distressful consequences of anal fixation; these activities are known as *compulsive actions* and *compulsive thoughts*;

(viii) a characteristic way of exercising control over or preventing ill-consequences is a compulsive omnipotent 'undoing' of current actions, with the further aim of 'undoing' past actions that are represented by current ones, thus rendering phantasies of faecal play undone.

These have to do with ostensibly non-personal symptom-formation. The psycho-pathology of overt personal relations may be put as follows:

(a) the attempt to gratify anal activities conflicts with various pressures to adopt substitutes; the former is somewhat unsuccessful and the latter accepted without 'good grace'; in these pressures the mother is essentially involved;

(b) having to yield, yet having to remain in a state of conflict, arouses hate against the mother;

(c) since there is hate as well as desire for the mother, there is sharp ambivalence;

(d) the pleasurable affect of defecatory power combines with hate to form sadism;

(e) to diminish ambivalence, the male unconsciously displaces part of his love for his mother to his father, which is distinct from his primary affection for his father;

(f) this displaced love gives rise to some degree of latent homosexuality;

(g) he interprets his mother's failure to satisfy his faecal interests and anal erotism as stemming from hatred; because of his desire for her, he has to accept her hatred; it is a case of her hatred being better than nothing—hence masochism;

(h) disapproval of faeces and anal erotism becomes centred in the superego; as a manifestation of this, the subject adopts an 'admonishing' attitude.* (This is a different piece of theory which is by no means so intelligible as it looks, and which would require some filling out.)

I believe this account is faithful to Freud's ideas and intentions, despite the difficulty of establishing references; admonishment did not figure in the classical picture, but it is in the same spirit.

IV. Object-relationship and the classical theory

Influential exponents of post-classical analysis work entirely in terms of object-relations. Freud's ideas in general contained a combination of object-relations and object-

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* Melanie Klein (1937) refers to coercion as characteristic, and Abraham (1942, p. 430) has described the same thing, without giving it a name. Admonishment is almost always coercive, but in settling for a single word I choose 'admonishing' because coercion alone can often be selfish in a narrow sense whereas the obsessional tends to coerce for a principle (superego selfishness is not on a par with id selfishness).

less aims. Clearly the difference in point of view must have an important bearing upon the theory under discussion: on the object-relational view the classical theory, or some of it, would have to be re-interpreted or replaced; on the classical theory, the difficult problem of connecting object-relational to object-relationless hypotheses still confronts us. Because of the importance of the subject it is desirable to discuss it here, but it has to do with theory at a different level from that of the rest of the paper; it therefore constitutes a more or less independent problem and the reader will find that it turns out in the end to be more or less a digression—the thesis of this paper is complete even if the present section is omitted.

The diagnostic factors discussed involved both object-relations and object-relationless zones; and so do each of the accounts dealing respectively with symptom-formation and personal relations. Does this in any way vitiate the theory? If the psychology exclusive to object relations is correct, does this render the object-relationless part of Freud's theory untenable? Again, a somewhat different point, are sublimation and reaction-formation non-object-relational? Freud's theory of phases was almost unquestionably non-object-relational: a bodily zone was regarded as a *location in which* pleasure-as-such was to be found, and only later become a *channel through which* pleasure was sought from an object, or through which aggression could be directed against an object.* For instance, in the phallic phase the penis is valued for its own sake and not for its object-relational rôle *vis-à-vis* a woman; in the anal phase faeces are valued similarly and not necessarily as a way of expressing a relationship to another person.

* If this were *not* the correct construction to put on the classical view, it becomes hard to make sense of the stress placed during the last quarter of a century upon object-relations as basic in psychoanalysis, or to make sense of the libido theory and primary narcissism and of the theory of Freud's remarks about zones.

On the other hand, just as with development the penis could be viewed as having an object-relational rôle, so with faeces: at a certain stage the infant values them not only as good in themselves but uses them as presents to give to others. Again the penis can be used in aggressive relations, and likewise faeces for anal-sadistic attack.

The immediate question is whether in Freud's view obsessional disorder arises from a conflict about the valuation and erotism in itself or about the use to which it might be put in a living object-relationship. It might seem plain from the construction of the theory offered above that Freud traced the disorder to object-relationless factors. But the position is not so simple as this. For, as transpires from the treatment of the individual patient and also from Freud's own case histories, the psychopathology of an individual patient, as Balint (1932, 1957) first pointed out, was interwoven with object-relationships: in case histories, obsessions were never merely obsessions with the enjoyment of anal substitutes, nor were compulsions merely counter to these; obsessions were always of wishes directed against someone and compulsions were efforts made to nullify these.

It would seem to follow that, to reconstruct the theory on Freud's own ground, we must explain symptom-formation not in terms of the valuation of anal erotism but in terms of the wish, e.g. to use faeces sadistically and anal erotism seductively.

But let us look more closely. When distress about faeces and anal erotism leads to displacement, is this devoid of objects? There is no immediate answer to be readily found in Freud's writings, but a Freud-type view may be constructed. The distress arises from frustration and/or over stimulation. Are these, or are they not, associated in the infant's mind with a person? Did Freud hold that repression could take place in principle without, or did it need the intervention of, a person who was regarded as the author of, say, the frustration, however inevitable it might in fact be? It is quite likely that

Freud—perhaps wisely—never made up his mind about this. But a view that is theoretically coherent would be that these conditions *are* object-relational, in other words that the infant *does* ascribe frustration and the like to another person, but none the less that the zone-pleasure is free of object-relations—that is to say, the phase valuation may not involve anyone, though all interference with its satisfaction does involve someone.

It is not necessary to try to settle this question here: for the possibility just mentioned above shows that Freud's diagnostic theory may be consistent in itself and moreover would not be incompatible with the exclusively object-relational approach that characterizes clinical investigations.

It remains to mention sublimation and reaction-formation. The latter gives the appearance of taking place under the pressure of object-relations; if symptom-formation originates in the impact made by an object-relationship upon the valuation of a zone, it might be presumed to be the same with reaction-formation. Sublimation may seem to be in a different situation, because, for example, painting, as a sublimation of smearing, does not appear to have a relationship with another person. True, the object does not; but the pressure inducing the process would have the same effect as that just described. Thus these two normal functions might be assimilated to an object-relational view of Freud-type.

Evidently a decisive answer is not easily obtainable and the problem would require a separate investigation devoted to it. Various possibilities seem open, and hence it would seem that the problem of the present paper may be handled without first settling the issue about object-relationships.

V. SUBLIMATION AND REACTION-FORMATION: ORBITAL INTROJECTS

The classical theory attributes reaction-formation and sublimation as well as obsessional neurosis to the repudiation of interest in anal activities. The processes are all different and have been conjectured only in outline. What follows will be an attempt to construe the mechanisms involved, so as to provide a detailed, even though not complete, account of these two higher mental processes.

General

We launch out from a central feature of the preceding discussion, that distress about faeces is regarded by the child as the mother's fault. But the task of carrying out the construction is facilitated by making use of a distinction between nuclear and orbital introjects (Wisdom, 1961), where the nuclear introjects form the core of the self and the orbital introjects are internal objects. This may be briefly explained as follows.

When an object is introjected, there are two possibilities. It may form part of the inner world of the self and be viewed by the self as an internal object. The self thus has relations towards an object within the orbit of its world, and the object may therefore be called an 'orbital introject'. On the other hand, when introjected it may form part and parcel of the outlook of the self: the self may look at the world, including its inner world, through the eyes of this introject. Such an introject is not an orbital but forms part of the core of the self, which may be called its 'nucleus'. In this primitive form of structure the self does not have object-relations towards the nucleus, but only towards the orbitals.

Hypothesis 1. To avoid distress over faeces, the child gives up his display of interest in them.

Hypothesis 2. He replaces this by introjecting faeces, which thus become an orbital introject.

Hypothesis 3. The discarded external faeces would be regarded henceforth as bad.

Hypothesis 4. The orbital introject would be regarded as good.

Hypothesis 5. Preservation of this situation would require an orbital introject of a hostile mother (a superego component).

OUTER WORLD
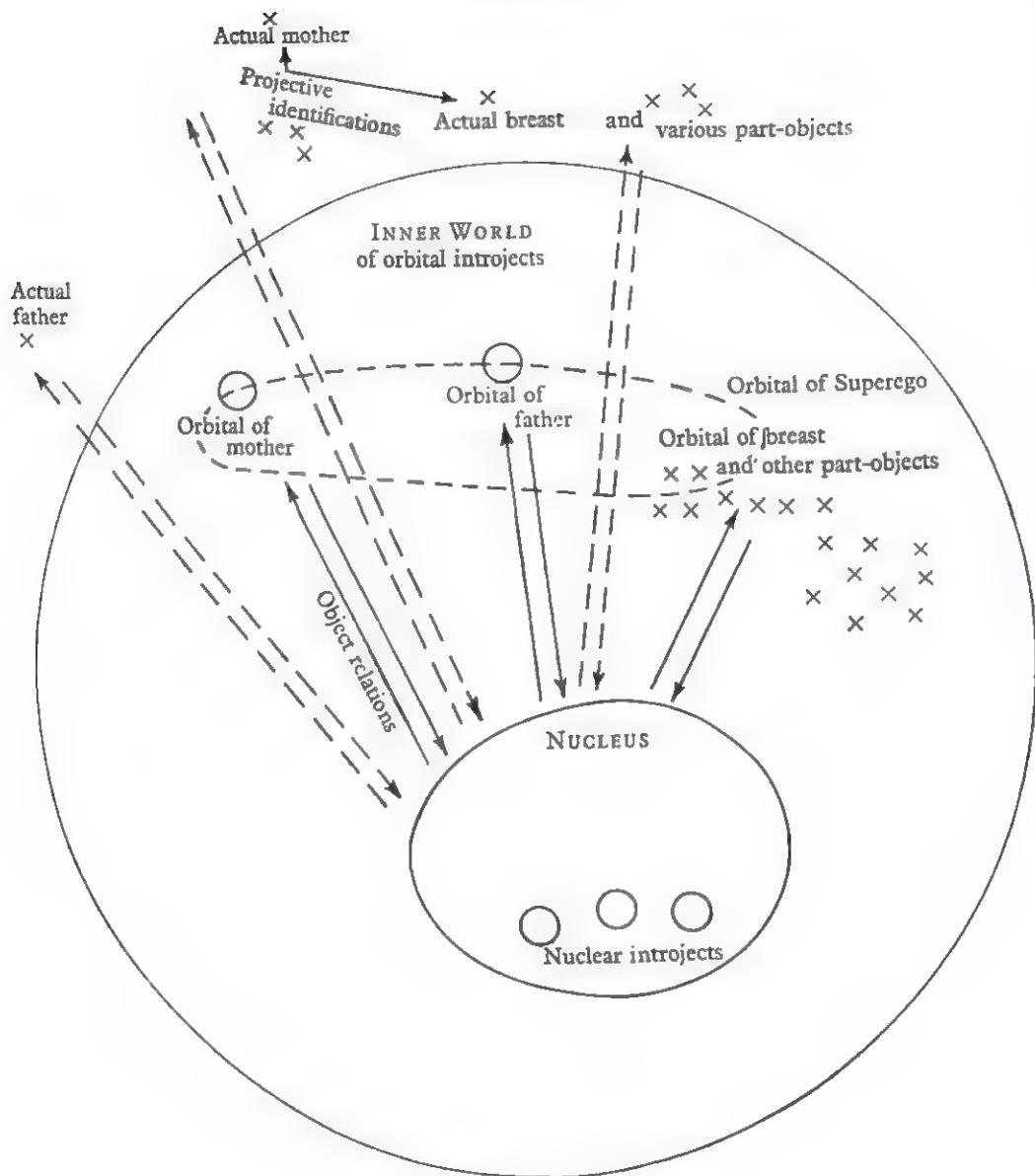
Fig. 1

Hypothesis 6. The threat from the hostile mother-image would consist of destroying the good faecal introject.

Special: sublimation

Hypothesis 7a. To avoid this loss, the faecal introject has to be transformed. This theory of the mechanism of the threat contains as a part a theory of orbital introjects and their relationships. It is a theory of psychic structure and does not in itself involve anything abnormal. According to it the faecal introject is not retained as a good object, nor is it turned bad; it is transformed by splitting.*

Hypothesis 8a. Transformation of the good

* It might be thought that this concept should not be used in reconstructing Freud's theories. But he not only recognized an obsessional patient's sense of being split (1909, p. 177) but also the splitting of affect from idea which he called 'isolation'.

faecal introject is effected by a limited destruction of it, consisting of splitting it into several separate objects, mainly consistency, colour, and smell.

Hypothesis 9 *a*. Provided one of these is kept split off, an alternative form of another one may be combined with the original third (e.g. in the absence of smell, a new colour can be combined with the old consistency, or in the absence of consistency, a new smell may be combined with the old colour).

Hypothesis 10 *a*. This is the basis of symbol-formation and hence of sublimation.

Special: reaction-formation

A very different way of handling the orbital introject of the hostile mother is open.

Hypothesis 7 *b*. The nucleus of the self, by projective identification, may (so to speak swell and so) enfold the orbital hostile mother-image (the subject thus includes a component of the superego in his character).* The child is now in a position to take a very different attitude towards his (good) faecal introject.

Hypothesis 8 *b*. He will now regard his faecal introject as bad. This would seem to be the basis of the puzzling feature of the 'reversal' involved in reaction-formation. In this situation the child will attack the faecal introject much more radically than in the process of symbol-formation.

Hypothesis 9 *b*. He will split the affect of valuation from the faecal introject, and be reluctant to attach it to any close displacements of faeces, such as dirt.

Hypothesis 10 *b*. He will attach value with full assent only to faecal opposites, bright and shining, colourful, hard, dry, delicately scented (e.g. honey), and as a further development, order, tidiness, hygiene.

* This would seem to underlie the defence-mechanism described by Anna Freud (1937) as 'identification with the aggressor'. An example from the 'Rat Man' will be found in Freud (1909).

These accounts, although they use a new distinction involving nuclear and orbital introjects, are perhaps as near as we can get to an explicit form of the intuitive ideas of classical analysis. Classical analytical writings give the impression of deriving sublimation and reaction-formation from repudiating the valuation of faeces rather than from that of anal erotism; and it may be noticed that these are the terms in which the above presentation is given. We must, however, consider whether similar derivations could be made in terms of anal erotism. Thus, analogous to hypothesis 1, we might have: to avoid distress about anal erotism, the child gives it up; and at first sight it might seem that we should have a similar sequence of hypotheses.

But there is an important difference. The splitting process in relation to faeces concerns an attitude toward faeces as things existing independently of sensations aroused by them; but in relation to any form of erotism the splitting involves at least getting rid of a sensation. This raises a difficult problem. Repudiation of a form of erotism means separating it from the activity characteristic of a certain site with which it is normally combined, the erotism being re-attached elsewhere and experienced in some other activity. This might, for convenience, be called, to use a telling word coined by Schur (1955), 'desomatization'. It is a really extraordinary psychical achievement for which there is no suggested explanation; but that it occurs there can be no real doubt.

Subject to these qualifications, and to an additional proviso that analogous to an internal object there can exist in phantasy nuclear internal functions, all the hypotheses may be repeated in terms of anal erotism, with a nuclear function to take the place of an orbital object. We should thus obtain sublimatory activities in addition to objects of sublimatory interest, and reaction-formation activities in addition to objects of reaction-formation valuation—for example, painting as well as pictures, cleaning as well as clean places.

A possibility that may be of considerable importance suggests itself here. It is seldom mentioned (Hartmann, Kris & Loewenstein (1949), however, do mention it) that certain manifestations of aggressiveness can be a sublimatory activity. This would be displaced not from anal erotism but from angry excreting. Further, this activity could be used to attack faeces, and in this a sublimatory activity could be used to bring about a reaction-formation.

The theory given so far may enable us to understand *why* a child may have to turn against his own faeces, but this new conjecture would provide a mechanism enabling us to understand *how* he can do so. It may be formulated as a hypothesis as follows:

Hypothesis θ. Desomatized anal attacking feelings may be used against faeces.

On this view it would seem that anal activity is more fundamental than the attitude towards faeces. In § IX below, a conjecture will be developed from this of the existence of a further normal process, additional to sublimation and reaction-formation.

VI. DEVELOPMENT CONSEQUENCES: NORMAL

Normal development in the anal phase involves anal sublimation, such as art of various kinds, commercial decorating, or accountancy, and anal reaction-formations such as orderliness and cleanliness. The first would seem to be a transformation of the faecal introject by splitting, preserving split off aspects, and representing them in a certain way by symbols; or else by desomatization of anal activity. The second would seem to rest upon the recognition of bad faeces as an orbital introject and the creation of new good orbital introjects with opposite qualities to those of faeces; or else the desomatization of anal activity. In both, faeces are given up both as external and internal objects.

In these processes of normal development, it seems to me to be a mistake to suppose either that the quality of good faeces or a covert hankering after bad faeces is somehow preserved in the transformations. If the hypothesis that symbols are formed by splitting up the qualities of faeces, then the quality of being faecal is not preserved; likewise on the main hypothesis about reaction-formation, in a newly valued object, such as money, bad faeces are not present in disguise, but repudiated and replaced. What is preserved is the attitude of valuation, originally attached to faeces and now attached to the new combinations of faecal aspects split off from faeces.

VII. DEVELOPMENT CONSEQUENCES: PATHOLOGICAL

If in normal development the valuation of faeces is completely abrogated through sublimation and reaction-formation, it is otherwise with pathological processes. Sublimation and reaction-formation may not absorb the whole of the valuation of faeces and anal erotism, and when this residue exists we have to consider what happens to it. There may be an inability to give up an attachment to it. Alternatively the faeces and anal erotism may come to be regarded as bad and none the less an attempt may be made to form an attachment to them. Or alternatively an attempt may be made to resuscitate them as good. In any case there is fixation: faeces are felt to be good despite efforts made to deny this. And this will provoke the mother-imago. With anal erotism, however, there arises a paradox, which does not arise over faeces, namely that erotism because it is repudiated is no longer actually felt in connexion with anal activity and yet is somehow locked up in it (which looks like a contradiction). But it should be remembered that even at the height of the anal phase the erotism is not felt continuously but only from time to time; there is no question of postulating that it persists all the time in some form; similarly, where there is fixation, there is no need to make any postulate of this kind; all that is required is that the subject should want to re-experience the erotism. Such a potentiality

would be enough to invoke the hostility of
the mother-imago. The next step would be
that the threat from the hostile mother-
imago would arouse hostility against her;
and one obvious way of expressing this would
be to attack her anally with faeces. The
subject is now doubly threatened: both for
treasuring faeces and anality and for attack-
ing his mother; and his conflict here is not re-
solved by sublimation and reaction-formation.
He therefore needs additional defences.

VIII. Elaboration of the classical psychopathology

The steps in the formation of obsessional
neurosis already described do not need
modification as a result of the account given
of sublimation and reaction-formation in
terms of orbital introjects: the first seven
hypotheses of the classical theory explain
much of obsessional neurosis, without signi-
ficant alteration; but this new account will
enable us to explain some features more
satisfactorily, and some features that are not
accounted for by the classical theory.

The pathological situation is that, for
whatever reason, there remains, after sublima-
tion and reaction-formation have done their
best, a fixation on anality: the child continues
to regard faeces and anal erotism as good and
to be fascinated by them even though he
partially regards them as bad.

If we now introduce the idea, developed in
connexion with reaction-formation, of the
nucleus of the self enfolding the orbital
introject, the hostile mother-imago, we can
see at once a conflict between the new attitude
of the child disapproving of his faecal intro-
ject and anality, regarding them as bad, and
his fixated attraction to it. To avoid persecu-
tion by the orbital introject of his mother,
because of his persisting interest in faeces and
anal erotism, he must reinforce his projective
identification with his mother-imago: because
his interest in the faecal introject and erotism
would arouse the threat from the mother-
imago and make it difficult for the child to

maintain his projective identification with it;
there would therefore be a constant effort to
maintain or increase this projective identifica-
tion. In addition, because of having a partial
identification, the self is simultaneously two
entities, a wider and a narrower, for it in-
cludes both its nucleus and the introject on
the one hand, while on the other hand it is not
identified with the introject, so that it is an
object for that introject: hence, taking the
wider form of himself, he would, as projec-
tively identified, disapprove of the narrower
form of himself, as not projectively identified,
for his interest in faeces and anality. In the
sequel we have to see how far this idea can
be used; first a few minor results.

One consequence is that, in the patho-
logical processes, it is good faeces rather than
bad that are presumed to be wanted, and if
bad faeces fascinate, it is because their bad-
ness is not fully believed in.

The source of masochism becomes plainer:
it would arise through identifying with the
hostile mother-imago, so that the subject
could get satisfaction arising from his hurt.*

With such a projective identification per-
vading a person's life, the natural consequence
would be that he would display towards the
world a 'ritualistic' attitude—obedience to a
set of norms and forms, conscientiously
observed, about which there is no zest except
that of carrying them out—and an admonish-
ing attitude towards anyone who fails to
conform to his ritualistic conception, and in
particular anyone who tolerated disorder,
untidyness, lack of cleanliness, or anything
reminiscent of faeces.

IX. Repugnment

That concludes the attempt to construct
the classical theory of reaction-formation and
sublimation,† the classical diagnostic theory

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* This presupposes that in masochism physical
pain is a symbol of psychical trauma (not the
other way round).

† Not of course the general theory of sublima-
tion, but a particular theory of it in the setting
of obsessional disorder.

of obsessional neurosis, and in the light of this the classical psychopathology and theory of normal development. But, wholly within the spirit of the classical outlook, a further addition may be made.

The hypothesis θ opens up the possibility of distinguishing two attitudes. The mechanisms discussed above centre on the hostility of the mother-imago to faeces and to anal erotism; by these means the processes of reaction-formation by splitting and redistribution of properties and of pathology have been depicted. But let us consider a rather obvious hypothesis (accepted in classical writing in other contexts):

Hypothesis ϕ. An orbital introject that is turned bad can be got rid of as bad faeces by defecation.

Hence we can derive further:

Hypothesis ψ. And aggressiveness in this rôle is thus felt to be good.

Here we have a source of reaction-formation that is quite different from the main one discussed above. First, there the core of the process consisted of splitting something craved for, because the craving could not be tolerated or because it met with hostility; here it is not something craved for but something made bad because destroyed. Secondly, there the hostile power was an orbital introject (persecutory); here it is nuclear, because it comes from the sense that aggressive activity destroys—hence it is guilt-producing.

On close inspection one can see that this latter mechanism is hardly a 'reaction'-formation, for it does not involve the revaluation of something good, looking upon faeces as bad instead of good, for here faeces are assumed to be created as bad things through the destruction of a good thing (notably the breast). Thus this mechanism is much more like that of sublimation than of reaction-formation proper. Indeed it is the sublimation of an aggressive act. Since the term 'sublimation' has been, though it need not in principle have been, associated solely with erotism, there is a case for having an addi-

tional term. Based on the more or less obsolete word 'repugn', I would suggest coining the word 'repugnment'.

It is reasonable to suggest that reaction-formation is the attempt of the obsessional character to achieve normal functioning, but that it involves a defence mechanism of identifying (projectively) with the hostile orbital introject, which must surely exact its toll; on the other hand, the mechanism of repugnment could characterize the normal character. It is interesting to note that the mechanisms are different in kind, thus sharply differentiating the normal and the abnormal, and yet the familiar manifestations of the two are the same, thus making the normal and the abnormal look as if they differed in degree only.

X. CENTRAL PROBLEMS

Classical writing on the subject illuminated many of its aspects, but left certain questions, some quite important, some fundamental, without answers. Thus in the construction given in § III of the classical psychopathology, gaps may be noticed in the handling: i.e. the following problems, which though not the most fundamental or of considerable importance, were not solved:

(i) How does affect become isolated from defecatory displacements?

(ii) How is the 'admonishing' attitude to be explained?

(iii) There was no definite indication whether what is sought after in anal fixation is good faeces denied to the subject, or whether he is fascinated by faeces even though he regards them as bad.

The subsequent construction of sublimation and reaction-formation, and elaboration of normal and pathological development in terms of orbital and nuclear introjects provided at least partial answers to these questions *en passant*—(i) in terms of splitting, (ii) through projective identification with an orbital introject (which also explains masochism more fully), and (iii) that in normal

development the answer is neither, while in pathological development, what the subject clings to is the feeling that faeces are good.

Other gaps will also have been noticeable, and these concern the three great theoretical problems of obsessional disorder (to be taken up in a further paper):

(1) the explanation of fixation at the anal phase;

(2) the nature of the difference between *obsessional neurosis and obsessional charac*ter: it is not clear why the obsessional reaction should vary between compulsive and ritualistic actions (which marks the difference between obsessional neurosis and obsessional character; for though the theory explains compulsions it does not explain the 'ritualistic' attitude);

(3) The phenomenon of the 'compulsion to repeat' (traumatic experiences) has always been regarded as a mystery.

XI. SUMMARY

Metascientific procedures help to get into perspective the extensive knowledge of the phenomena of obsessional neurosis and such hypotheses as there are about it, with a view to uncovering problems that are unsolved. There are described the syndrome; Freud's theory of the anal phase; and the development of anal fixation, i.e. failure to relinquish valuation of faeces and anal erotism. Aetiological factors discovered by Freud are enumerated, and an attempt is made to construct the classical psychopathology in terms of Freud's ideas The relevance of object-relations is discussed but it is concluded that they are a digression so far as the present problem is concerned.

An attempt is also made to construct along classical lines the processes of sublimation and reaction-formation, which is facilitated by a distinction I have previously made between nuclear and orbital introjects, and the classical ideas of normal and pathological development are further elaborated.

A new hypothesis is introduced: that anal attacking feelings may be used against faeces. So the attitude towards anal activity is more fundamental than the attitude towards faeces. Thus an orbital introject, turned bad, can be got rid of as bad faeces by defecation, leading to the feeling that aggressiveness in this rôle is good. This process is different from reaction-formation and for it I coin the word 'repugnment'; it could characterize and therefore sharply differentiate normal from abnormal character-structure.

This attempt to construct the classical theory of various processes step by step provides at least part of the answer to certain unsolved questions, e.g. to do with isolation and certain obsessional attitudes, and makes precise what valuation is put upon faeces.

Three theoretical problems are left for a subsequent paper: (1) the explanation of anal fixation; (2) the nature of the difference between obsessional neurosis and obsessional character; and (3) the explanation of the phenomenon of the compulsion to repeat.

REFERENCES

ABRAHAM, K (1911). Notes on the psychoanalytic investigation and treatment of manicdepressive insanity and allied conditions: page ref. to Abraham (1942).

ABRAHAM, K. (1924). A short study of the development of the libido, § 1: page ref. to Abraham (1942).

ABRAHAM, K. (1942). *Selected Papers on Psycho-Analysis.* London: Hogarth Press and Institute of Psycho-Analysis.

BALINT, M. (1932). *The pregenital organisations of the libido. Primary Love and Psycho-Analytic Technique,* pp. 52 ff. London: Hogarth Press and Institute of Psycho-Analysis, 1952.

BALINT, M. (1957). Criticism of Fairbairn's generalisation about object-relations. *Brit. J. for Phil. Sci.* 7, 323–4.

FREUD, A. (1937). *The Ego and the Mechanisms of Defence,* ch. IX. London: Hogarth Press and Institute of Psycho-Analysis.

8

FREUD, S. (1909). Notes upon a case of obsessional neurosis. *Stand. Ed.* **10**. London: Hogarth Press and Institute of Psycho-Analysis.

FREUD, S. (1913). The disposition to obsessional neurosis. *Stand. Ed.* **12**. London: Hogarth Press and Institute of Psycho-Analysis.

FREUD, S. (1918). From the history of an infantile neurosis. *Stand. Ed.* **17**. London: Hogarth Press and Institute of Psycho-Analysis.

HARTMANN, H., KRIS, E. & LOEWENSTEIN, P. M. (1949). Notes on the theory of aggression. *The Psychoanalytic Study of the Child*, **2**, 21. London: Imago Publishing Co.

JONES, E. (1913). Hate and anal erotism in the obsessional neurosis: reprinted in Jones (1923).

JONES, E. (1923). *Papers on Psycho-Analysis*, p. 556, 3rd ed. London: Baillière, Tindall and Cox.

KLEIN, M. (1937). *The Psycho-Analysis of Children*, p. 232. London: Hogarth Press and Institute of Psycho-Analysis.

SCHUR, M. (1955). Comments on the metapsychology of somatization. *The Psychoanalytic Study of the Child*, **10**, 119 ff. London: Imago Publishing Co.

WISDOM, J. O. (1961). A methodological approach to the problem of hysteria. *Int. J. Psycho-Anal.* **42**, 231.

The role of the father in early mental development

By VERA VON DER HEYDT*

When I began to be interested in the figure of the father, I tried to find out about research work done on him. I was surprised to discover that there exists hardly any literature about him. The purpose of this paper is first to show some of the underlying causes for this phenomenon, and how neglect has affected the father himself and through him the family. Secondly, I will discuss the father's particular purport as a person and as a principle. From this material the father's significance in psychotherapy will be clear by implication.

Freud was very much concerned about the role the father plays, but he was particularly mindful of the negative castrating aspect of the father from the son's point of view, essential in the Victorian era. Jung wrote one short essay on the father: *The Significance of the Father in the Destiny of the Individual*, which was published in 1909; Jung revised it twice, the last time in 1948. This essay is important as Jung states in it his theory that the magical hold and influence parents have over their children is due not only to the personality of the individual parent, but to the power of the archetype which stands behind them.

In later works remarks about the personal father are scattered through Jung's writings; mainly, however, he examines the father–son relationship as it appears in mythology, in religion and in alchemy, and then he takes this archetypal relationship symbolically as an image from which the interdependence of self and ego in the individual psyche can be understood.

Jung's very particular attention was devoted to the mother and to her double role: life-giving and nourishing, and her destructive and devouring aspect: he was concerned to show how these two aspects belong to the archetypal mother—nature, matter—as can be seen in the figures of the mother goddesses all over the world and also appear in every individual woman. He stressed this aspect of life because the earth and the body, the mother world, had been repressed and diminished for centuries, particularly in the Christian world.

What has happened since, however, is that mother, and in particular the personal mother and her role, seems to have been over-emphasized to the point where all responsibility is laid at her door; all later neurotic trouble in the child is traced to a faulty relationship at the breast: and the role of mother is stressed almost as against the role of wife or the role of woman in the round.

Not so long ago the father was the most important person of the family, and obedience was owed to him by his wife as well as his children. He was the sole breadwinner, he was responsible for the welfare of his family; for education, choice of profession, etc. He also carried responsibility for the actions of his family.

Now the wife is the husband's equal economically and legally; mother's greater importance in the family unit has been proclaimed, and so: father is dethroned in the family.

Much of father's responsibility has been taken over by the Welfare State, and so it is the State which carries to a certain degree an authority which used to be his: father is dethroned by the State.

The Church used to uphold the father's authority over his family automatically, as being a reflexion of the eternal authority of the Father who is in Heaven. The Church is more alive now to the dangers of such an

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identification: so, father has been dethroned by the Church.

The father's status has changed therefore in the external world; he is no longer carried collectively as the predominant figure: this has had consequences and has affected the individual father. It has made him insecure and uncertain as to his role in the family, and so he tends to withdraw from the family leaving decisions to the 'mother', thereby fatally strengthening her animus.

Furthermore, values which belong to the transpersonal father, to the father-world, are being questioned and attacked: law, order, discipline, self-control, morality, taking responsibility, having responsibility are all queried and even have been declared to be damaging to the individual's development. Other father-world values have also been attacked: for instance the courage of pilots, so it has been said, has to do with the negative side of the *puer aeternus*, with a compulsion to be flying in the clouds away from the reality of life; the courage needed for mountaineering we are told has something to do with a desire to overcome mother and trample on her breasts. Infantile motives and motivations are doubtless contained in all our actions; but, there has been so much attention given to the negative shadow side—forgetting the body which casts it—in much psychological teaching that it has seeped through to the general attitude as 'nothing but'.

Dr Bruno Bettelheim, the Austrian psychoanalyst who is now Professor of Educational Psychology in the University of Chicago, was imprisoned in concentration camps for several years. In his book *The Informed Heart* he describes his experiences and the conclusions he came to with regard to some aspects of psychoanalytic theory. I quote:

'While in camp, I was little concerned with whether psycho-analytic theory was adequate and only with the problem of how to survive in ways that would protect both my physical and moral existence. Therefore what struck me first was the realisation that those persons who according to psycho-analytic theory as I understood then, should have stood up best under the rigours of the camp experience, were often very poor examples of human behaviour under extreme stress. Others who, according to the same body of theory and the expectations based on it should have done poorly, presented shining examples of human courage and dignity.

It would just not do under conditions prevailing in the camps to view courageous, life-engendering actions as an outgrowth of the death instinct, aggression turned against self, testing the indestructibility of the body, megalomanic denial of danger, histrionic feeding of one's narcissism or whatever other category the action would have to be viewed from in psycho-analysis. These and many other interpretations have validity in terms of depth psychology or the psychology of the unconscious, and they certainly did apply. Only viewing courageous behaviour by a prisoner within the spectrum of depth analysis seemed ludicrously beside the point. So while psycho-analysis lost nothing as far as it went, it went unexpectedly, and in terms of my expectations, shockingly short of the mark.'

The archetypal father has disappeared into the unconscious, is repressed and is therefore causing disturbances, confusion and unpleasant symptoms. The personal father according to reports by social workers is also disappearing; in Britain and America the high incidence of desertion, separation and divorce is remarked upon and the effect this has on the mother and children; mother's anger and distress is felt by the children; a negative unreal image of the father is presented to them by the mother which is often strengthened by personal unfortunate experiences. A sense of shame is activated in the child for not having been able to hold father's affection, and also shame is felt for being 'different' from other children. As a consequence both a girl and a boy distrust the possibility of achieving a relationship with the opposite sex; the girl may be afraid of man for the rest

of her life, and the boy finds it difficult to develop or trust his own masculine powers as the male ideal in the person of the father was destroyed.

These difficulties assailing the deserted mother and children have been noted for some time. Very rarely, however, does one find any mention of the problems of the husband-father which drove him away from his family. In America it seems that a high percentage of men left their families after the permanent arrival of their mothers-in-law in the home.

A milder form of disappearance is experienced in our present-day society through the fact that father works so far from home that his family, certainly his children, hardly ever see him.

When the father's disappearance is occasioned by his death, particularly if he was a war-hero, the mother may present an idealized unreal image of him to her children; in this case feelings of inadequacy and of guilt may arise in them because of the hopelessness of ever being able to be worthy of such a saint-like person.

How serious the consequences of father's disappearance are is seen from a Home Office Research Unit Report on *Delinquent Generations* 1961.

'. . . the peak excess criminality characterises those born in the seven year period 1935/36 to 41/42; the greatest crime-proneness is found to be associated with that birth-group who passed through their fifth year during the war. Whether this means that disturbed social conditions have their major impact on children between the age of four or five is not proved, but it is a likely hypothesis. A previous crime-prone group was born in the years 26/27, 27/28. This birth-group coincides with the worst part of the depression of the 30's. The concomitance of these two results seems unlikely to be due to chance. There appears to be something particularly significant in social disturbances occurring in the fourth or fifth year of a child's life. Perhaps the deprivation of mothers is important in very

early life and paternal deprivation later, say between four and five years of age. But the depression did not deprive children of parents. Children born during the 39/45 war have not yet shown any tendency towards excess criminality.'

This report is noteworthy as it highlights: (1) the difference between the role of the parents, mother important earlier and father later; (2) the importance of 'experiences' during the 4th and 5th year; (3) the fact that 'absence' of the father relates to (*a*) actual absence, e.g. war, and (*b*) psychological absence, e.g. out of work.

In the beginning of life the child telescopes mother–father into one figure. In early children's drawings one can see sometimes a human figure with a penis which the child calls mother; father is an appendix of the mother, he is the penis. Gradually as consciousness emerges the child differentiates father from mother and recognizes him as a person in his own right, and mother as a person in hers; this is a completely new situation and one of the greatest significance.

The tremendous crisis and conflict in the life of every child with the possibilities of traumatic consequences, and in which love and loyalties are put to the test appear in the Oedipus situation. Freud put this conflict around the age of 3–5. Jung asserts that a child's essential characteristics have evolved by then, and that it is possible to foresee the kind of collisions there will be between the child and his parents later on. This implies that the child himself can be aware at that time of the differences between himself and his parents, and this may sharpen the inner conflict. Furthermore, it is at this time that a child is confronted with rivals in the form of siblings which can make a child feel rejected and deprived. It is understandable, therefore, that father's actual presence at such a time is of extreme importance: actual, not nominal; it is through and by the emergence of 'an other' person that discrimination, possibility of choice, a feeling for conflicting values is established; in other words: the father's

presence is needed for a sound development of the ego. When father's otherness can be experienced as a constructive, positive force supplementing mother's, even though at times at variance with her and yet also valid, it is easier for the child to dis-identify from the mother, to establish himself according to his own law, and eventually to form a relationship with a thou. This is a particularly difficult problem for the girl as her first relationship, that with the mother, is a relationship of sameness, and therefore it seems to her as if all relationship is based on identification. For a boy, it is vital that he should be able to project hero-qualities on to his father which enable him to break the tie with mother. There is one other aspect which can play an essential part in the life of a child, namely the role of father as comforter; mother comforts when in pain or distress of body, but it is father who is the comforter when in pain or distress of soul or mind. Father the comforter is also father the provider.

DIFFERENCE BETWEEN THE FUNCTIONS OF MOTHER AND FATHER

Mother is the bearer of new life and the birth-giver: as image she remains for ever the world of origin, of timelessness, the womb to which one would return for warmth and security and fulfilment; she is the world which provides food and protection; she is the earth in which one would sleep. Mother's timelessness is nature's rhythm in which birth and death alternate; there is constancy about this rhythm and about this image, irrespective of whether the actual experience of the personal mother was good or bad: mother represents the unconscious, the instinctive side of life as it has been and always will be on this earth.

There was a time when the connexion between coitus and conception was unknown or not admitted; it was thought that fertilization happened through a spirit: a spirit in the form of man, creature, voice—a presence. Father did not exist then, only mother.

Mother existed without father, but there was never father without mother. Father came into being during historical time when man's creative forces as being more independent of nature than woman's were recognized.

Father embodies consciousness; his realm is reason and knowledge, light and sun; in a patriarchal society it is the elders, the fathers who govern, who pass laws and keep tradition alive. For the child it is the father who is the mediator between the exciting world outside and the home: his attitude to work, ambition, success, competition, affects and colours the child's attitude and can make him long to grow up or be afraid to do so. It is the father's strength which provides security and encourages self-confidence, and his authority which helps the child to discover his boundaries. This is the way in which the father gives birth to his children.

It is understandable at a time when the father's role has become so problematical to himself that he passes on his insecurity to his children: father-lessness brings about ego-deficiency: the overemphasis on the role of the mother encourages a false ego which relies on opinions and collective ideas and operates in a kind of gang or pack mentality. The father who is there and yet not there can be much more difficult for the child than a father who believes in himself. When father does not embody authority and security a child's feelings of resentment, aggression, frustration and despair at not being able to project ideals and values on to him may be vented on society and the state.

In an environment in which mother's powers are too seductive there is the danger of being drawn back into her realm; it is dangerous for the individual to remain too near her values without the compensatory values of the father-world holding the balance: the unconscious overcompensation is the overemphasis on rationality, our 20th-century mind, materialism, 'our childish passion for rational enlightenment' of which Jung said that it was the cause of many neuroses.

However, in some way mother, woman is becoming more conscious of her potentially dangerous side; man has yet to apply his more developed sense of consciousness to himself as father: he seems to have little idea of his positive side, but even less of how destructive he can be.

There are different kinds of psychologically absent fathers; one of them the father 'out of work' who does not 'provide', another is the weak father who is despised by his wife secretly or overtly. He may be weak as a character, he may drink, or gamble, or run after women, or he may be inefficient in a general way. His feelings of insufficiency, nonentity and insecurity may affect his children in the form of an anxiety neurosis, frigidity, impotence, or in the form of having feelings of being stuck: others can, I can't: unconscious resentment can make a child's contempt for the father's weakness more bitter.

Then there is the jealous Jehovah-like father who blusters and is angry and hurt if his will is not done or his advice taken on every issue. This may be one of the causes which lead to a compulsion neurosis, and his children may be people who try too hard, who are obsessed with being successful, who tend to overstrain.

In a general way one finds that whenever someone is abject about rules and regulations, or flaunts them automatically, if any one is afraid of or has difficulties with external authority, there is a father-complex in the background. This is also true for those who have difficulties with time: fear of time; over-punctual or unable to be punctual.

In a *Sunday Times* series on the father, Mr Crossman gave a description of his father which is typical of many; I quote:

'A life lived within the confines of the law turned a natural caution into a conformity so intense that he was scared in the end of any kind of moral or intellectual innovation. He was a lawyer who loved the law as an ancient historian loves his period of Roman history, or an archaeologist his site. Proposals to reform it seemed to him as vulgarian as the idea of pulling down Westminster Abbey in order to put a more practical church in its place...he suspected the speculative mind, and resented the questioning of ultimate beliefs. His conservatism was as deep and uncritical as his Christianity.'

This kind of father can be one of the most dangerous ones for the child: negative, castrating as he inhibits life by resisting change, development, transformation. In myth the image of this father is Chronos who devoured his children because he did not want them to be in time and space. In the external world he is the father whose ideas are based on the collective conscious attitudes of his father's era, and he fears the current ones. He is terrible because he teaches to resist and opposes the new; and he attempts to fixate consciousness in his way, allowing for no other.

The ego is the carrier of consciousness, of ideals and intentions of life—in time. Whereas mother in her eternal aspect represents the earth which does not change, the trans-personal father represents consciousness as it moves and changes, and in this sense father is subject to time, subject to ageing and death, as his image changes with the culture he represents. Constancy about change is the secret of the father principle as spirit, his activating, fertilizing, life-giving creative power which comes from another plane, or adds another dimension to the earthly plane. Change is the dynamic aspect of life in this world, and it is the truly positive father who allows it.

When a girl experiences father in his destructive aspect and fights him, she can lead a relatively undisturbed feminine existence; because she rejects only what is alien to her. Nevertheless, her capacity for sexual relationship may be damaged, also her potential for lucidity and objectivity; she may remain stuck on the obscure, ambiguous, unconscious level of her nature. As her ego development is impaired, she will rely on opinions and be rebellious in a collective

way; and be much more contaminated by her father's collective ideas and attitudes than she knows or can admit.

As is well known, it is the father who is the first to arouse the girl's sexuality with regard to man. The incestuous desires are deeply repressed by the child; but often the father represses them as deeply and is quite unconscious of his desires and of the strength of his feelings for, and jealousy of, his daughter. It depends on his attitude to his feminine side, to his relationship with his wife, to the relationship he had with his mother as to how he will react to his daughter's desires and fears: and his reaction will influence the girl in her attitude to her emotional life and in her relationship to man.

When her feelings are ignored or laughed at: she will have feelings of shame and inferiority which go very deep and are difficult to overcome.

When father reacts too strongly a girl may become very frightened of physical contact: father becomes disgusting; she will fear father's reaction and her own feelings too because they have been made to feel disgusting—by mother.

Fantasies and day-dreams about an ideal father colour ideas about an ideal man who is utterly removed from reality. Result of this mixture of fantasy and repression is that a girl regresses to the level of primitive woman and a 'spirit' has to father her child; relationship is neither present nor expected; or else in the arms of her husband or lover a woman 'has' the child from her 'spirit' lover —who *may* be another man: and then the child is a very special child and particularly beloved.

In this connexion a phenomenon has to be mentioned through which it is possible to learn a great deal about the secret longings physical and spiritual which have to do with the father: the women, married and unmarried, who fall in love with men who all carry the mantle of father: doctors, analysts, clergymen. Very complicated and tragic situations can arise, though this experience can also be a gateway to new insight, greater consciousness and understanding for the inner meaning of incest.

Reasons for choice of husband are connected with the father: if a woman denies this it means that she has a father-complex and is unconscious of it. Every little girl expresses a wish to marry a man exactly like or exactly unlike her father. Problems that arise in marriage between the wife and her husband —as far as the wife is concerned—have to do with the unsolved problems between the woman and her father, or even with problems which her parents had been unable to solve between themselves. This is the case when a man turns out to be like father, a drunkard, running after women, or impotent: the problem then is so urgent that it appears 'outside', though in fact it has to do with that part within which is father. Unfortunately, even though made conscious, it does not always mean that such problems can be solved within marriage; a marriage may have to break up: this may be the price that has to be paid for greater consciousness, though it is obviously not always greater consciousness that leads to a marriage being broken up.

Finally: for the girl the father is the mediator of the male principle as spirit, as well as of the masculine sex: as spirit he represents the essentially other. The actual experience of the personal father may be helpful and give confidence in undertaking marriage as a means for creating a union in the external world, and also a desire eventually to go on the inner quest which may bring about an experience of one's totality and essence. The actual experience with father may have been disastrous, and then an outer relationship may not have come about or succeeded: but, the inner way, however difficult, may prove fruitful in bringing to consciousness a sense of meaning and purpose into a life in which the spirit of man was hidden behind a flaming Jehovah, or else, even worse, into a life in which there was not even an anger to encounter but just nothingness and a void.

Father's relationship to the son has particular characteristics: through Jung's Word Reaction Test it is known that typologically the son is closer to his father than to his mother. 'Alikeness' may create difficulties in any relationship, all the more in the one to the father, particularly if the father recognizes his shadow side in the son, or the other way round, the son in his parent.

In our society the son's fear of the father is largely due to the Oedipus situation and the well known conflict which accompanies it. The incest wish in the boy differs from that of the girl's: he wants to be with mother, inside her, alone, without father, warm and safe, but he does not think in terms of having a child from her as does the girl with regard to her father. For the boy the sexual act does not mean the creation of new life, but it is copulation and a way to prove his virility and his ability to compete with his father. This is where one meets the boy's ambivalence: his envy of his father's greater power also means that he admires his father; furthermore, he may feel a certain tenderness for the father who possesses mother because of his identification with her and he may even feel possessive for him. Real difficulties arise when mother is 'too welcoming', giving the impression that her son is more important to her than her husband, or else if she is too rejecting of the son's feelings: problems arise too if the boy feels that his father treats him in too humiliating a fashion. Then the boy may find himself in a no man's land of no existence, and can only escape by going into fantasy—into masturbatory fantasies in which he is omnipotent, and which cut him off from outer reality and relationship.

Fantasy may prevent the boy from fighting his father—he may be too afraid, or too removed from reality; but he may still remain utterly dependent on the personal father's approval and acceptance: castrated, he either loses the connexion to his own creative powers, to the transpersonal father-creator in himself; or else he flees into identification with the father-god as Holy Spirit and remains in a possessed state of heavenly inflation: both these states signify that the ego is missed out: too much fear has maimed the spirit of aggression.

An early conflict with the father on the emotional plane in which he appears either as a hostile or despicable figure is not the only level on which the father-dragon has to be overcome.

The father–son conflict typifies the great problem of all time, the problem between the generations; it is not always recognized in all its poignancy as the Oedipus situation is only one aspect of it. Rivalry between father and son is different in kind from rivalry between equals; a very particular helplessness is experienced by the child who is in the power of the father, and by the father who is in the power of time. Mythologically this conflict is expressed in the stories of the ageing gods and the fights between the old and the young ones; historically the problem was acted out by royal persons governing the community; the old king fought to retain his power, the young king designate attempted to wrest the realm from him. It is only in comparatively late patriarchal civilizations that this controversy between old and young came to be associated with father and son. Erich Neumann contends that the essential motive for the son's hostility against the father is contained in the problem of generations, and is the son's need to find his own validity; the young hero has to fight the old out-moded world of yesterday in order to establish his own inner law and discover the values of today. The collective law as represented by the father has to be fought by the son with all the misery of fear of punishment, temporal and eternal, which is attached to this rebellion: in order to progress from the traditional moral code to the discovery of conscience.

The idea of hostility to and impatience with yesterday's values and sufferings is a familiar one and runs like a red thread through history. The father's enmity and fear of his son can be deduced from the extent of the custom of infanticide which was practised

almost universally among all peoples, and certainly among the Assyrians, Babylonians, Jews; and from the practice of exposing children as among the Indians and the Greeks. The first-born son in particular carried the father's ambivalence of feeling, and he was sacrificed in order to appease an angry god. The angry god, then as now, is the father's anger at the new life which will supplant him, and the fear of death. The killing, however, is also a sacrifice, because there is not only hate for the son but love too and the idea of life being continued through him.

The conflict between an individual father and son can be resolved when both recognize the angry jealous god in themselves, and when they are able to differentiate between the actual person, be it father, be it son, and the fantasy image born from projections, wishful thinking and archetypal ideas. Only too frequently do fathers and sons believe that their terrible relationship, their emotional difficulties are purely personal ones, whereas this conflict is a collective one which concerns every father and son.

In various religions the father–son relationship is at the centre; in Jewish and Christian thought it is so on a personal level as well as depicting the relationship between God and man. In a parallel way the image of the father–son relationship is used in Indian philosophy as describing the relationship between true self and ego.

For the Vedantic Indian, the physical father and the whole domain of the physical senses, organs of reason, as well as inherited customs and prejudices of one's race must be put aside before one can enter into the full possession of one's intrinsic self.

These ideas link up with alchemy in which the problem of 'generations' is expressed as the rejuvenation, transformation and rebirth of the father, the old man or the old king who is ill, sometimes evil and petrified, who has to die: by dissolving in water or in the mother's womb he can be reborn, renewed as the son or the young king. By implication the alchemists drew a parallel between the old king and the young king on the one hand, and God and his son on the other: an indication that God as Father needs to be reborn.

Jung doubted that the alchemists were conscious of this implication: I believe they probably were: in the daily living of the liturgy and in the concept of the Trinity the pain of constant transformation is expressed: the need for sacrifice, the willingness to be sacrificed and the spirit by which this is accomplished: always anew the sacrifice of the yesterday—the yesterday we hold so dear.

There is one religion, Islam, which does not tolerate the term 'father' in reference to God; Muslims understood the word 'father' only in the sense of physical generation which means that if God is father he must have a wife. And so they will not even admit the term in the metaphysical sense: God being the father of all men.

The reconciliation between the generations is not only an outer problem, it is essentially an inner one: from the child's point of view it is ultimately the coming to terms with the internalized inner parent image; from the father's it is the coming to terms with his child: the outer and the inner too. The first step is to recognize that there is an inner fantasy image, and not exclusively an outer reality. The unhappy child within, in parent and child, has to look at the expectations and the disappointments, at the contentments, at the envy and greed as well as at the gratitude and generosity in himself, and these feelings have to be permitted, and, if possible, understood. All these emotions have to do with the earliest time of life, with mother, and it is often arduous to get at these experiences in analysis. But, there is a level on which we are deeply influenced by the father of which we may remain unconscious much longer than of any emotional disturbances experienced at the breast; it is a level which is unconscious but not repressed: it is the level on which father is there as an appendix of mother, as relationship to mother, unknown, vague, known only through and by mother: and yet

he is there; his attitude of thought, his behaviour, his spirituality are conveyed indirectly, and subliminally experienced. All these attitudes form part of the internalized father image: we may remain unconscious for a long time to what an extent we are identified with and conditioned by this image. Even a dawning of this situation heralds a new phase: it means that we are separating the inner parent figures, that we can experience the importance and the validity of both parents, that we are withdrawing projections: with the ego thus strengthened there will be less neurotic conflict, the inner parent images can join in a new deliberate union, and can give birth to self.

BIBLIOGRAPHY

ADLER, G. (1961). *The Living Symbol.* London: Routledge and Kegan Paul.

ALLENBY, A. (1955). The father archetype in feminine psychology. *J. Analyt. Psychol.* **1**, no. 1.

BETTILHEIM, B. (1961). *The Informed Heart.* Thomes and Hudson.

Vortraege ueber das Vaterproblem. (1954). Herausgegeben von W. Bitter. Stuttgart: Hippokrates Verlag.

FORDHAM, M. (1944). *The Life of Childhood.* London: Routledge.

JUNG, C. G. (1949). *Die Bedeutung des Vaters fuer das Schicksal des Einzelnen.* Zurich: Rascher.

JUNG, C. G. (1944). The archtypes and the collective unconscious. In *Coll. Works,* **9**, part 1.

JUNG, C. G. (1944). The development of personality. In *Coll. Works,* **17**.

JUNG, C. G. (1955). *Mysterium Coniunctionis.* Zurich: Rascher.

NEUMANN, E. (1949). *Ursprungsgeschichte des Bewusstseins.* Zurich: Rascher.

WILKINS, L. T. (1960). Delinquent generations. Home Office Research Unit Report. London.

SOCIAL CASEWORK: January, October 1954; April 1957. Family Service Association of America.

Genealogical bewilderment in children with substitute parents

By H. J. SANTS*

INTRODUCTION

The term *genealogical bewilderment* was first used by Wellisch (1952), who became interested in the fact that an apparently large number of adopted children had been referred to the child guidance clinic at which he and the present writer were then working. A study of the maladjustment of these adopted children suggested that, in addition to the general causal factors of maladjustment, adopted children have the burden of what may be called *adoption stress*, i.e. the stress to which adopted children are subjected as a result of their adoptive status. A factor which frequently appears to be present in adoption stress is genealogical bewilderment. The purpose of this article is to describe genealogical bewilderment, to indicate the kinds of children who experience it and to consider the significance of genealogical knowledge in mental health.

A genealogically bewildered child is one who either has no knowledge of his natural parents or only uncertain knowledge of them. The resulting state of confusion and uncertainty, it will be argued, fundamentally undermines his security and thus affects his mental health.

Not only adopted children may lack knowledge of natural parents. Genealogically bewildered children may be found in any family where one or both of the natural parents is missing. Thus step-children and foster-children may show this condition as well as those reared by one natural parent in the absence of the other, most commonly the illegitimate children of unmarried mothers. What the children being considered have in

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common is *at least one unknown parent*. Children with unknown parents may not always show overt concern about their lack at every stage of their development but clinical knowledge of such children suggests that at some time, very often in early adolescence, they will begin searching for clues. Once they have begun, their preoccupation with the task can reach disturbing proportions. One 8-year-old fostered boy characteristically said, 'I do not know nearly enough about my Daddy. I want to find out someday where he is. I'd like to know his address and send him a letter.' It is striking how such children will gather directly or indirectly every shred of evidence which they feel will put them on the right trail. The preoccupation amounts to an obsession in that genealogically deprived children feel that all their troubles would be solved by a solution of this one.

GENEALOGICAL KNOWLEDGE AND MENTAL HEALTH

The psycho-dynamics of genealogical bewilderment will be considered in this article in relation to (a) the self-image and (b) the Oedipus complex. In discussing genealogical bewilderment in this way the intention is to relate the concept to two basic aspects of child development: the child's relationship with his mother and the triangular relationships later formed with his father and mother. The child's self-image is rooted in the first stage of development and his images of sexual roles in the second. This psychoanalytic approach is based especially on the works of Klein (1948, 1959).

(a) The self-image and genealogical bewilderment

The importance of the concept of self in mental health has been emphasized by many child psychologists and a sample of their findings can be found in Hurlock (1955). She states that 'until the individual establishes a *stable* concept of self he will be uncertain about his ability, his status in the group, and how he compares with others.... Those with stable self-concepts have higher levels of self-esteem....'

In order to gain an understanding of how the concept of self develops in children it is necessary, even for the limited purposes of this study, to consider the earliest months of a child's life during the nursing years of infancy. Studies of infancy, and maternal care have been notably surveyed by Bowlby (1951) and scrutiny of the life-long effects of the infant's relationship with his mother probably derive mainly from the insights gained from analytical work with young children carried out by Klein from 1921. This approach, now widely used in general clinical work, can be summarized briefly as it is used for present purposes as follows. Klein contends that the infant has an *awareness* of the mother from the earliest weeks and that by about the third or fourth month has developed a sense of trust and mis-trust in relation to her. Later, at about the fifth or sixth month he has developed a sense of security and insecurity. These aspects of self developing in the paranoid and depressive positions permanently prescribe the extent to which the self feels persecuted and accepted and are the earliest roots of the child's concept of self. Klein's views on the origins of the self are here accepted as the basis of later developments.

From the first year onwards the child's awareness of his environment gradually extends from his mother or mother substitute to other members of his family. At each stage he appears to seek to establish a stable concept of himself as belonging to his extended environment because feelings of not belonging rouse earliest, deep-rooted and disturbing anxieties of maternal rejection. The various ways in which parent-regarding feelings are displaced on to objects outside the family are discussed by Flugel (1921). He traces the displacement of parent-regarding feelings on to more distant relatives, to the family as a whole and finally to other units of which the developing child becomes a member, e.g. school, university or town.

Of the displacement on to the family or clan he says; 'In certain persons again—especially in members of an aristocratic caste or in others who are able to trace their descent through a long line of ancestors—some important aspects of the parent-love come to be attached to the idea of the whole family of which they form a part; the tendencies to esteem, obedience, admiration or idealisation originally aroused by the child's immediate parents being transferred to the family or clan regarded as a social group, which has existed in the past, exists now in those of its members who happen to be living and will continue to exist in the descendants'. In adolescence when the normally maturing child is satisfactorily weaning himself from his parents through displacement of tender feelings on to wider groups such as clan or family, it could be argued that the genealogically deprived child is handicapped by not knowing which clan or family he belongs to. Such children appear to be disturbed by this blockage of possible displacement.

That the self-image or body-image is based on more than an image of the physical body is emphasized by Schilder (1935). He examines its extension into clothing and tools and the social environment and concludes, 'A discussion of a body-image as an isolated entity is necessarily incomplete. A body is always the expression of an ego and personality, and is in a world.' What needs now to be examined is why genealogically deprived children who are denied an extension of their self-image into their hereditary family feel so emotionally deprived. An illuminating des-

cription of the genealogically deprived is given by Hans Andersen in his story of *The Ugly Duckling* but before turning to this source it is perhaps necessary to anticipate possible criticisms of the use of literature as evidence, since, in this section on the self-image, use will be made of a story of Hans Andersen and, in the following section on the Oedipus Complex, attention will be given to the account of the legend by Sophocles.

What the great writer possesses is the power to associate what less articulate beings have failed to explicitly associate and to so express the associations as to be able to communicate them to others. In the course of brief child guidance therapy the patient is rarely articulate enough or analysed sufficiently for complexities of his phantasies to emerge through his defences. With the great writer the richness of the material overflows the defence systems. The point is dealt with by Russell & Russell (1961): 'Analysis largely consists in stimulating the activities of exploration and communication, and one of its effects is always an increase in literate, articulate and imaginative writing, which (subject to differences in specific talent) may be used as one simple criterion of success. *A fortiori*, then one of the surest and swiftest ways of studying human behaviour is the study of, for instance, Shakespeare, or Dostoievsky or Sophocles or Ibsen.' And again '...in studying human behaviour our richest materials are those provided by the great writers. One of these can tell us more than a thousand patients studied daily for years, if they lack his freedom to communicate.'

To turn now to the *Ugly Duckling* story, an account is given below in some detail because step by step it illustrates so well the plight of the genealogically deprived. In this case it is a swan deprived of knowledge of his swan's genealogy by being hatched in a duck's family.

The swan is rejected because he cannot do what the others in his family can do as a result of his different genetic endowment. Persecution leads to depression and wander-

ing (symptoms found so often in the genealogically bewildered child). At one time the young swan is fostered by an old woman who already has two other foster-children, a cat and a hen. The cat despises him because he cannot curve his back and purr and the hen because he cannot lay eggs. The ugly duckling's heredity at this stage of his development allows him only to claim swimming as one of his abilities. He ventures to say, as many foster-children have done, that his foster-family do not understand him and is told, by the hen, 'You've got nothing to do, that's why you get these whimsies. You try laying eggs or purring, and you'll get over it. We don't understand you, don't we?...thank your Maker for all the kindness people have shown you. Haven't you got a nice warm room to live in and company from which you can learn a thing or two?...I am talking to you for your own good and when people tell the unpleasant truth, then you get to know who your real friends are.' The ugly duckling then does what other foster-children have done before, he runs away 'out into the wide world'. One afternoon he sees some birds which strangely inspire him. They are swans but he does not know that. He has never seen such beautiful birds but is not jealous of them. He encounters further rejections and hardships but then suddenly finds he can flap his wings more strongly than ever before and that he can fly. Then once more he meets some swans: the ugly duckling recognizes the beautiful animals and a feeling of strange sadness comes over him. He fears they may kill him but he does not care; he must join them. '" Please kill me", said the poor little creature, and meekly stretched his neck along the water and waited for death. But what do you suppose he saw in the clear water? He saw his own image. But it was no longer that of a clumsy, dirty, grey bird, ugly and awkward, but of a lovely swan. *It doesn't matter at all being born in a duck-yard, if you come out of a swan's egg!'*

One of the ugly duckling's difficulties was that none of his foster-parents knew that he

was a swan. They did not know his genealogy. Consequently they could not understand the significance of his skills nor envisage his potentials. The ugly duckling showed his need to identify with others in order to feel that he belonged but he could not identify with animals differing so much from himself in appearance and performance. On first seeing swans he has some peculiar insight into their affinity with himself but it is only when he has reached maturity and sees his mature image that he can see that he is one of them and thus identify successfully.

There are a number of points here which are relevant to a consideration of the difficulties of a child with parents who do not share his heredity. Because of the different heredities there may be marked and peculiar differences in appearance and intelligence and skills. Differences in appearance can severely hamper a child's capacity to identify with his parents in order to reinforce any feelings he may have of belonging as the result of loving care. A description of the processes involved in identifications has been given by Sandler (1961): 'Identifications go on in fact all the time and are one of the most normal and useful means through which the child grows up and is educated. The little boy who takes into himself the masculine attributes of his father is paving the way towards a healthy and masculine adult life'. The nature of the identifications greatly affects the outcome of the Oedipus Complex. Identifications with the mother in the case of the girl are important for her development of femininity. It is the balance of masculine and feminine identifications with both parents which is of course important in the complexities of the Oedipal relationships. In a discussion of Sandler's paper, Parnell (1961) describes the genetic aspects of identification. Somatotyping of 900 male students and their parents revealed that 'a very much higher proportion of the sons (60–70 %) who got on well with their fathers actually had physiques (somatotypes) that were very similar to their fathers. Where the father's and son's physiques were very

different, the proportion of sons who got on well with their fathers was comparatively low (20 or 30 %). Parnell suggests that imitation occurs much more readily where the person the son wants to imitate is similar in 'somatotype and in genetic structure' to start with. Commenting on Parnell's findings, Sandler considers that it is much easier to identify with someone who resembles oneself and that physical resemblances have 'something to do with the outcome of the Oedipus Complex, and the subsequent character of the child may be influenced by the mother more than the father, or vice versa'.

If differences in genetic structure between natural father and son can hamper identifications it seems likely that identification will be even more hampered when there is no hereditary link between father and child. In this case the grossness of the physical differences which may occur could perhaps prevent any successful identification with profound and complex repercussions on the character of the child.

A point worth raising here concerns identifications in the child living with his natural parents. Identifications can take place because of physical features characteristic of the paternal or of the maternal genealogy. Physical features can make a boy identify more easily with the maternal relatives or a girl more easily with paternal relatives. The side of the family to which the child is assigned in the family thinking is often an important aspect of the general psycho-dynamics of family relationships.

Hans Andersen's interest in genealogy which found expression in his story of the ugly duckling may well have reflected his own paternal deprivations and his unusual appearance and clumsiness as a boy. Andersen was well aware that he was not just telling naïve stories for children. As an old man he wrote in his diary (Pickard, 1961): '...children only understood the *stuffage* and not until they were grown up could they see and grasp their full meaning'. Pickard describes the Andersen family. Hans Christian was born two

months after his mother's marriage to a cobbler, Hans Andersen. She already had an illegitimate daughter who lived in a foster home and later became a prostitute like the mother's sister. When Hans Christian was 11 years old his father died. Two years later his mother married another cobbler. The males in Hans Christian's family were many and weak. The mother had at least three partners known to Hans Christian. Hans Andersen was 'very clever but so very sad'. He used to read rather than cobble and for some years before he died went off on his own travels. The grandfather was eccentric to the point of being considered insane and never addressed one single word to his grandson except once when he apparently failed to recognize him. Hans Christian was a curious, even perhaps *ugly* boy, exceedingly tall and with awkward movements. His mother was the dominant personality and Hans Christian must have struggled to avoid her domination by identifying with his paternal heredity. This was weak and confusing; and the facts of his family as he knew them must have led him at some time in his childhood to have doubts about his paternal genealogy.

To some extent the story of the ugly duckling is an account of Hans Christian Andersen himself and, as evidence, can be so considered. Andersen, however, was not in the unfortunate position of knowing nothing of the identity of his father. When a child of unknown parentage is encountered the consequences of his deprivation become revealingly apparent. Very few in our society are in this position and it is difficult for the majority to envisage the extent of the consequences. Some further explanation for the need of known ancestors may come from a consideration of *ancestor worship*.

In civilized societies religious belief tends to assume the form of belief in a first mover or creator but in polytheistic primitive societies there is often also a belief in the power of ghosts of deceased ancestors as well as belief in impersonal spirits associated with natural objects. Spencer (1893) even goes as far as to say, 'Using the phrase Ancestor Worship in its broadest sense as comprehending all worship of the dead, be they of the same blood or not, we conclude that Ancestor Worship is the root of every religion'. Certainly, ancestor worship is found among Hindus, Parsees, Chinese, Japanese, Polynesians, some African races and American Indians and it can be assumed that, whatever its nature, there is a widespread human tendency to invest ancestors with a deepseated emotional interest. For some people ancestors are regarded as mediators between themselves and God. For those holding this belief it would be disturbing not to know the identity and possible status of one's mediators.

Some form of ancestor-worship can be seen also in contemporary society and has been described by a leader-writer in *The Times* (1961): 'Few men are completely without interest in their forebears, because at its lowest this is mainly an extension of their interest in themselves.... For children, for instance, how swiftly and eagerly they respond to tales about their great or greater grandparents.... Perhaps that is part of the secret of the hold that grandparents so often seem to have upon their grandchildren: they have already, as it were, a foot in the ancestor clan.... Some few families are well equipped with everything that feeds such curiosity, with portraits and letters and priceless heirlooms of varying degrees of beauty. Some try to fill the gap with research.'

At the beginning of this section an outline was given of the development of the extended self-image with its basis in the self formed in infancy. Through processes of identification other people can be incorporated into the self-image. Schilder has said that 'the relation to the body image of others is determined by the factor of spatial nearness and remoteness and by the factor of emotional nearness and remoteness'. He also says that 'the dead...do not disappear from the community of the living. They remain in this community as long as their pictures are revived in any members of the community.'

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The anthropological evidence indicates that related ancestors have a special emotional nearness and it is they who appear normally to be incorporated into our self-images. No doubt this is not always a conscious incorporation except perhaps, in Flugel's words, 'in members of an aristocratic caste or in others who are able to trace their descent through a long line of ancestors'; but the disturbance ensuing when it is not possible to identify and incorporate suggests that some incorporation of ancestors into the self-image does normally take place. In most ordinary families in our society identification with parents and grandparents may be enough to induce a sense of belonging, so essential to emotional security. There seems to be the need to identify at least to this extent with biologically linked predecessors. In considering the *biological* link, moreover, it may be that most people are in some way aware of the fact that they contain a small physical part (the germ-plasm) of their parents and remoter ancestors: there is reasonably a strong emotional need to know from whom this comes. Most people are also aware of the fact that not only physical characteristics but also intellectual and emotional characteristics are in part genetically determined. This has been believed long before the rapid modern developments since Mendel. If consideration is to be given to the part played by phantasy in human thinking and behaviour then effects of knowing or not knowing one's heredity need to be examined. *Not* knowing would appear to be incompatible with the secure self-image.

(b) *The Oedipus Complex and genealogical bewilderment*

An excellent starting point for a discussion of genealogical bewilderment and the Oedipus Complex is the Oedipus *myth* as it survives in Sophocles's play *King Oedipus*. In Watling's translation, Oedipus after he has married Jocasta gives her this account of his origins as he then knew them.

My father was a Corinthian, Polybus;
My mother a Dorian, Meropé. At home
I rose to be a person of some pre-eminence;
Until a strange thing happened—a curious thing—
Though perhaps I took it to heart more than it
    deserved.
One day at table, a fellow who had been drinking
    deeply
Made bold to say I was not my father's son.
That hurt me; but for the time I suffered in silence
As well I could. Next day I approached my
    parents
And asked them to tell me the truth. They were
    bitterly angry
And I was relieved. Yet somehow the smart
    remained;
And a thing like that soon passes from hand to
    hand.
So, without my parents' knowledge, I went to
    Pytho;
But came back disappointed of any answer
To the question I asked, having heard instead a
    tale
Of horror and misery; how I must marry my
    mother,
And become the parent of a misbegotten brood,
An offence to all mankind—and kill my father.
At this I fled away, putting the stars
Between me and Corinth, never to see home again,
That no such horror should ever come to pass.

Oedipus was the *adopted* child of the King and Queen of Corinth. Following the indiscreet taunt of the drunkard that he was not his father's son, his *genealogical bewilderment*, which may well have been present before, reached unbearable proportions. The pattern here of turning to the parents for the truth and not being satisfied will be familiar to all workers with adopted children. Line by line the description given by Oedipus echoes that of many adopted children. The Oedipus myth, however, is much more concerned wtih the total ramifications of the triangular family relationships than might be supposed from the limited use made of the myth by Freud (1900): Freud neglected the part played in the complex by the attitudes of the parents. The Laius Complex and the Jocasta Complex partly determined the intensity of the Oedipus Complex but Freud

in 1900 was mainly drawing attention to incestuous tendencies in the child and putting forward the then startling discovery, following his self analysis, that 'it may be that we are all destined to direct our first sexual impulses towards our mother, and our first impulses of hatred and violence towards our father'. Since Freud there has been abundant clinical evidence supporting the hypothesis that such tendencies are present in children and it is these tendencies and consequent fears that may explain some of the intensity of the desire to identify natural parents.

A characteristic of the genealogically bewildered, particularly from adolescence onwards, is their relentless pursuit of the facts of their origin. They visit the nursing home where they were born, interview nurses and question adoptive relatives. Oedipus expresses this need when he says 'I ask to be no other man than that I am, and I will know who I am'. And again 'I must pursue this trail to the end, till I have unravelled the mystery of my birth.' If Freud's hypothesis that there is a universal deep-seated fear of incest is accepted then another explanation is provided for the intensity of the desire to identify the natural family. People of unknown origin would have a fear of unknowingly committing incest. Irrational though the fear would be in the case of incest with the natural parent (and of murder of the other natural parent) fear of incest with natural siblings would be quite rational. Such is the intensity of conscious and unconscious Oedipal anxieties that the complications for the genealogically bewildered should not be lightly dismissed.

GENEALOGICAL KNOWLEDGE AND CHILD CARE

A hypothesis from recent child psychology as well known as any to child-care workers is that 'the quality of the parental care which a child receives in his earliest years is of vital importance for his future mental health', Bowlby (1951). Since the publication of the W.H.O. Report concern about the quality of

parental care has rightly been an important consideration when attempting to safeguard the mental health of children. The report was the outcome of a decision by the United Nations to make a study at the end of the Second World War of 'children who are orphaned or separated from their families for other reasons and need care in foster homes, institutions or other types of group care'.

Many child-care workers have interpreted the conclusions of the W.H.O. Report to mean that, in assessing a placement for a child in need, the main criterion should be the quality of loving care likely to be given to him. From this it could reasonably be assumed that if substitute parents are likely to provide better care than natural parents then any such child transferred soon after birth would be happier with the substitutes. To some extent this is a fair assumption. Psychoanalytic findings would support the view that basic aspects of mental health would be better provided for by the better nursing in infancy. But even in infancy there are dangers in this simplification. 'Loving care' cannot be prescribed in a set of rules and the nursing of a child not born of the nursing mother cannot be the same as the nursing of a natural child. As adoption workers have found, the relationship between child and substitute mother has special complexities. But it is in considering the child's needs *after* childhood that genealogical factors may be relevant in taking a decision about the best provision for a child in need.

It is indeed true that 'there are thousands of childless homes crying out for children and hundreds of Homes filled with children in need of family life' (Report of Croydon Children's Officer). Realization of this position inclined many workers immediately after the Second World War to favour adoption as the best means of providing the family life likely in the light of psychoanalytic evidence to best further the mental health of the child in need. The Hurst Committee in 1954 stated that 'there can be no doubt that adoption is generally a much

more satisfactory solution than any form of institutional care or even fostering'. In 1946, 21,000 children were adopted in England and Wales in comparison with only 3000 in 1927. It is true that the Hurst Committee also recommended that the adopted child should be brought up in the knowledge that he is adopted but despite the fact that most Adoption Agencies recommend this many adoptive parents fail to give the child full information about his natural origin when he asks (N.A.M.H. Survey). In the adoption of children there is in most cases an implicit attempt to transplant the child from his natural family into his substitute family. The purpose of this study is to suggest that such a graft can never be completely carried out: roots in the natural family can never be severed without trace. It should be said, however, that adoption does further the interests of the child in many other respects such as his rights of inheritance in the substitute family. For the *orphan*, adoption may well be the best solution.

It has been argued here that all children need to know their natural origins. In the early days of legal adoption in this country following the 1926 Act the view was often held that it was in the child's interests to protect him from the complications of belonging to two families at the same time and that knowledge of his natural family should be suppressed. But the available clinical evidence supports the view that the past cannot effectively be suppressed. Children may hear of their adoption from other children or neighbours (N.A.M.H. Survey). Normal sexual curiosity inevitably leads to the facts of conception and in turn to queries about natural parents. Moreover, within the intimacies of family life, secrets cannot be indefinitely kept without giving rise to suspicion and consequent deterioration of relationships. If the child senses that facts are being withheld from him he will conclude that these facts are indicative of a tainted heredity. He will fill the gap from his own phantasies so that he may be more disturbed than by using the facts from reality.

An example of a natural past which is often quoted as being best suppressed is the not so uncommon case of the child who is the offspring of one parent who has murdered the other with the execution of the guilty partner. But even in such tragic circumstances the unfortunate descendant may be happier with his own judgement based on the facts rather by being subjected to attitudes based on attempting to behave as if the event had not taken place. A principle in common use in family therapy is that conscious acceptance of the known facts, intolerable though they may appear to be, tends to improve rather than worsen relationships. In the case of the genealogically bewildered, acceptance of the known genealogical facts may well be essential for adequate mental health. The *psychology* of heredity has recently been curiously neglected with the consequent neglect of *genealogical* deprivation.

REFERENCES

ANDERSEN, H. *Fairy Tales*. London: Wedenfield and Nicholson, 1958.

BOWLBY, J. (1951). *Maternal Care and Mental Health*. Geneva: World Health Organization, 1952.

CROYDON, COUNTY BOROUGH OF (1948–49) *Report of Children's Officer*.

FREUD, S. (1900). *The Interpretation of Dreams*. Trans. Brill, A.A. New York: Random House, 1938.

FLUGEL, J. C. (1921). *The Psycho-Analytical Study of the Family*. London: Hogarth, 1950.

HURLOCK, E. B. (1955). *Adolescent Development*. New York: McGraw-Hill.

HURST REPORT (1954). *Report of the Departmental Committee on the Adoption of Children*. London: H.M.S.O.

KLEIN, M. (1959). *Our Adult World and its Roots in Infancy*. London: Tavistock.

KLEIN, M. (1948). *Contributions to Psycho-Analysis, 1921–1945*. London: Hogarth.

NATIONAL ASSOCIATION FOR MENTAL HEALTH. *A Survey Based on Adoption Case Records*. London.

PARNELL, R. W. (1961). Identification in Children, Parents and Doctors. *Psychosomatic Aspects of Paediatrics.* Ed. MacKeith, R. and Sandler, J. Oxford: Pergamon.

PICKARD, P. M. (1961), *I Could A Tale Unfold.* London: Tavistock.

RUSSELL, C. & RUSSELL, W. A. S. (1961). *Human Behaviour.* London: Deutsch.

SANDLER, J. (1961). Identification in Children, Parents and Doctors. *Psychosomatic Aspects of Paediatrics.* Ed. MacKeith, R. and Sandler, J. Oxford: Pergamon.

SOPHOCLES. *King Oedipus,* Trans. Watling, E. F. (1947). London: Penguin.

SCHILDER, P. (1935). *The Image and Appearance of the Human Body.* New York: International Universities.

SPENCER, H. (1893). *The Principles of Sociology.* London: Williams and Norgate.

The Times (1961). Leading article, Sept. 18th. London.

WELLISCH, E. (1952). Children without genealogy: A problem of adoption. *Mental Health,* **13,** no. 1.

Patient cliques and the therapeutic community

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Modern concepts of the treatment of severe mental illness in a hospital setting have become increasingly based on the principle of 'therapeutic community' (Jones, 1953; Stanton & Schwartz, 1954; Caudill, 1958; Redl, 1959; Denber, 1960; Fleck, 1962). Fritz Redl has pointed out that the concept, 'therapeutic community' or 'therapeutic milieu', is generally ill-defined and in practice takes different forms depending on the particular hospital and particular staff involved. One component, however, which is generally accepted as intrinsic is a non-regressive or anti-regressive hospital atmosphere. In working out this atmosphere, many hospitals have utilized open wards, frequent staff or patient and staff meetings, group therapy, and various types of activity programmes (Denber, 1960; Fleck, 1962). However, relatively little thought seems to have been given in psychiatric literature or in clinical practice to the problem of the function and management of spontaneous patient groupings in a therapeutic community. Characteristically, it is noted only that a patient belongs to a friendship group, and the meaning of the friendships for his own motives is considered in individual therapy. Management of these groups is generally based on common-sense concepts of whether they are good or bad for the members or for the hospital as a whole; at best, they are handled on the basis of a rationale derived from individual psycho-dynamics alone.

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In this paper, consideration will only be given to a special kind of friendship group: the patient clique. Like other cliques in society, the patient clique is a group of three or more persons characterized by exclusive membership, intense interaction between members, and some stability over time. Also like other cliques, the formation of a patient clique is the result of complex social forces. However, the hospital staff frequently is not aware of the forces or strains within the hospital institution that tend to bring patient cliques into being. In fact, their response to patient cliques may actually be dictated largely by sociological considerations rather than therapeutic ones and they may not be specifically aware of this fact. Therefore, this study will not only deal with the origins and management of patient cliques but it will serve to illustrate basic social forces and therapeutic issues in the therapeutic community as a whole.

The authors made an attempt to gather information about cliques in psychiatric hospitals with a therapeutic community orientation. Relevant material was obtained about six separate instances of clique behaviour: three at the Yale Psychiatric Institute and three at other psychiatric hospitals. The major portion of the material was derived from interviews with observers (nurses, therapists and social workers at the Yale Psychiatric Institute and a sociologist at a private psychiatric hospital in Boston (N. Bell, private communication)) and, in two instances, the material was from published articles (Boyd, Kugiles & Greenblatt, 1954; Miller, 1957). One particular Yale Psychiatric Institute clique was studied more intensively than the rest, by means of doctors' records, nurses' notes and meeting transcripts

as well as interviews with staff members. No attempt at systematic observation of the clique could be made but the material about this particular clique suggested certain patterns of clique development which also seemed to be operating in the other cliques studied.

In analysing the six cliques, the authors found it difficult to divorce the forces dictating the staff's response to the clique from those leading to the clique development in the first place. In other words, patient cliques seemed to form partly because the patients anticipated that the staff would respond in a particular way to them. Therefore, the present paper will first examine some of the social forces that seem to govern staff responses to cliques and then derive some hypotheses about the forces that bring cliques into existence in the hospital. Next, the significance of these social forces for the therapeutic community will be discussed. Finally, an attempt will be made to evaluate the therapeutic significance of patient cliques and some considerations for clique management will be presented.

I. STAFF RESPONSES TO CLIQUES

Varying degrees of clique behaviour among patients, i.e. constant association of three or more people and fairly explicit exclusion of others, occur almost continually in a psychiatric hospital as in society at large. Generally, however, there is not enough exclusiveness, intensity or duration of interaction among members to classify the group as a clique. When patient cliques do form, they are, as mentioned above, often ignored by the staff. At first blush, this reaction does not seem hard to understand. In a democratic society, the ideological devotion to the concept of classlessness frequently leads to ignoring or actual denial of the existence of such phenomena as exclusiveness and snobbishness. Often this denial is based on a magical hope that these phenomena will go away by themselves. In the six instances of patient cliques studied by the authors, however, the cliques did eventually become of central concern to the

entire hospital community. Strikingly, in five instances out of six, the staff responded negatively; i.e. *it attempted to diminish the strength of the clique, get rid of it, or, as a minimum, dissipate its power.* This attempt varied from verbal disapproval in meetings and in individual therapy, to more active measures, such as activity regroupings, room changes, and discharges.

Although frequently no explicit therapeutic rationale for these negative responses were expressed at the time, it is possible to present some of the implicit considerations in the staff's behaviour. First, membership in a clique may encourage and perpetuate unhealthy personality trends in individual members. Anti-social and maladaptive behaviour, such as drinking, promiscuity, acts of violence and irrational resistance to authority may be supported by other members of the clique. In other ways, too, members may use the clique for the inappropriate expression of hostile and sexual impulses. Some therapists of patients belonging to one of the cliques at the Yale Psychiatric Institute felt in retrospect that their patients may have utilized the clique for such purposes as acting out phony mothering tendencies, getting support for denial of their illness or simply for perpetuating unhealthy tendencies towards snobbishness. Secondly, the clique may function to undermine a unified or therapeutic group atmosphere in the hospital. In small group therapy, phenomena such as pairing and exclusiveness among some of the members frequently tends to undermine therapeutic movement. In the same way, cliques may serve to obstruct the larger therapeutic community. This is particularly important in a setting wherein combined patient and staff meetings are oriented towards group therapy goals, i.e. expression of feelings and development of insight. Thirdly, unchecked anti-social behaviour by a clique may serve as an example for non-clique patients and tend to encourage expression of their anti-social tendencies. Fourthly, non-clique members, in many instances people whose major

problem is their tendency to be excluded from groups, may experience such severe exclusion when a clique forms that they regress in a way that impedes their individual therapy.

Another important reason for the disapproval of cliques, related to sociological considerations, may not necessarily be therapeutic. This is the factor of control and power; the staff may respond negatively towards cliques *because they are felt to be a threat to the stability and control of the hospital*. In the author's opinion, this may frequently be the basis of staff negativism without the staff being specifically aware of it. This response is analogous to the way school administrators react when student cliques become manifestly destructive and create a problem for school discipline. In general, the administration enforces strict curbs on clique behaviour in the school system. From the point of view of a social organization, the reasons for this kind of response are clear. It is a way of maintaining order to accomplish the purposes of the organization. It is a type of response which recognizes that to some extent the clique is alienated from the powers of the organization and, also, that it is motivated to create whatever disruptions it produces. If such disruptions are allowed to go without any recognition or enforcement of sanctions by the administration, one would expect that they would become more serious and would pose a direct threat to the power of the administration. Undoubtedly, then, the application of negative sanctions to the group and the force with which they are applied is an emotional response to the negativism and obstructionism of the clique.

It is important to note that, in many cases, a clique is not manifestly destructive nor is it especially negativistic or obstructionistic. This was true of at least one of the cliques at the Yale Psychiatric Institute which was opposed by the staff. The basis of opposition in such cases seems related to the fact that a clique may provide a focus and an organization for feelings of alienation and hostility to the staff even when it does not act out these feelings in manifest destructiveness or obstruction. In the hospital, as in any type of organization, informal ways of providing satisfaction for patients develop which are not provided by the formal or official organization. Specifically, various outlets for feelings of dissatisfaction or negative feelings toward the administration may be found. These feelings may be expressed openly and directly or indirectly through gossip or through collusion with specific dissatisfied staff members, either aides, certain nurses or certain residents. To some extent, such phenomena are in operation at all times. A clique specifically provides a focus and an organization for these feelings of alienation from the hospital administration and it provides individual patients with group support and sanction for their negative feelings. Staff opposition to a clique which is not manifestly destructive, therefore, may stem from an intuitive recognition of the clique's roots in negativism and the latent threat it poses to hospital organization and management.

II. The background of clique formation

At the Yale Psychiatric Institute a clique developed among eight of the more integrated upper socio-economic class (according to the Redlich & Hollingshead classification) patients on the open ward. The major activities of this clique were social, such as: evening parlour games, bridge, dining out and going to a local nightclub. These activities began somewhat slowly in September 1959. Initially the group was fairly loosely knit. Constant association and active exclusion of other patients was at its peak during the months of December 1959 and January 1960. The clique broke up fairly suddenly in February and March 1960 after the informal leader of the group underwent a psychotic regression in early February and was transferred to the locked ward. Also, overt negative pressure on the clique from the staff (primarily verbal disapproval at meetings and in individual contacts) began during the same month.

At the same time that this clique reached the peak of its activity during December 1959 and January 1960, the staff was very much involved in working out particular tensions of its own. Although staff tensions are certainly very common in psychiatric hospitals and exist in greater or lesser degree throughout the year, the staff's particular manner of handling these tensions at this time seemed to have a distinct form. For the purpose of simplification, the authors have characterized the staff's manner of handling these tensions as *withdrawal of affect*.

Before the peak of this clique's activity, staff tensions had centred around the residents' feeling that the permanent staff made arbitrary decisions about patients and took little interest in the residents' welfare. These issues were discussed in informal resident meetings and in individual contacts between residents and permanent staff. At the same time, the residents' affectual involvement with patients was withdrawn, or, at least, much reduced. The formal staff and patient–staff discussions specifically reflected concern over a problem of staff indifference to patient activities and many of the staff discussions centred around a resident who was most withdrawn from participation in both informal and formal staff activities and responsibilities.

In the authors' opinion the basic issue producing these particular staff tensions and the subsequent withdrawal of affect may be characterized as a *decision-making crisis* involving residents and permanent staff. In essence, this crisis centred around the residents' own concern about the effectiveness of their decisions regarding patients and a resulting conflict with the permanent staff. Residents are frequently in the ambivalent position of wanting to make their own decisions and being tempted to leave all decisions to their superiors. In the course of a residency programme, they tend to depend heavily on their teachers but are encouraged to take on more and more responsibility. At some point, they tend to deny their ambivalence and try to take over completely.

However, their superiors recognize that supervision is still needed and a crisis develops wherein the potential importance of specific decisions is magnified, limits of responsibility are unclear and the residents' ambivalence about their increasing independence is intensified. At the Yale Psychiatric Institute, this crisis was sharpened by the fact that residents were in their last year of residency and closer to total psychiatric patient responsibility than ever before. Their complaint that their superiors were not concerned with their welfare, although perhaps based partly on fact, seemed to arise primarily from their independence–dependency conflict. The subsequent withdrawal of affect from patients may have been due to negativism and avoidance of the main stimulus to the conflict or simply an active involvement in another interest: working through the crisis. The specific development of this crisis and withdrawal at that particular point in the year is hard to explain. Undoubtedly, a Christmas slump and general reassessment of achievements and treatment goals at the half-way point in the residency year played some part in this. Nurses, too, seemed to withdraw affect from the patients at this time. It is not completely clear why this occurred, but, as Caudill has pointed out, withdrawal of one status group in the hospital leads to reciprocal withdrawal and re-alignment of other status groups.

A year later, the residents at the Yale Psychiatric Institute (six different ones) were beginning to become less enthusiastic about their work and again expressed the feeling that the permanent staff was not concerned with their welfare. Staff discussions this time centred around a resident who was missing more meetings than others, and residents were criticized by permanent staff for not working hard enough and not being sufficiently involved in their work. Strikingly, at this time, a new patient clique reached the peak of its activity.

As for the remaining cliques studied, adequate information about the staff situation

at the time of clique formation was only available in two out of four cases. One of these was the case of delinquents referred by the court to the Boston Psychopathic Hospital which was described by Boyd *et al.* (1954). It is stated that these patients rightly felt discriminated against because they were not given any privileges of picnics, movies, occupational therapy, recreational therapy, ground privileges and the like that were given to other patients. The staff attitudes at this time are described as follows: 'Staff persons . . . were less interested in establishing personal relationships with these patients than with "sicker" treatment case patients' (p. 340). It is noted that the staff resented the fact that these patients were there on the basis of a judge's ruling while other cases could not be admitted no matter how seriously ill a psychiatrist might consider them to be. The peak of activity of this clique was expressed in destructive acting out. This is not surprising, but it is interesting to note that it occurred on a week-end when the size of the staff was greatly reduced. Also, it is stated that 'On Monday morning psychiatric decisions made on Friday (before the outbreak) were carried out' (p. 341) suggesting that the staff's withdrawal over the week-end was emotional as well as physical.

The other case occurred in a private psychiatric hospital in Boston. Here, a clique had begun to develop on a ward administered by a psychiatric resident who, in the opinion of the senior staff, had been doing an inadequate job of running the ward. Another resident was then assigned to the same ward and was given the senior position in directing the ward activities. At first, a great deal of competition developed between the two administrators. Then, both of them became less involved in ward activities and the disagreement between the two became a focus of staff meetings. It was at this time that the clique became most active, actively excluding others and at one point even threatening to gang up on another patient.

It is notable that in each of the cases a clique reached the peak of its development when the staff seemed to have withdrawn its affect in working with the patients. The peak of clique activity did not occur at the same time as the peak of staff tension. Rather, it came slightly after when the staff was seeking to gain some distance from its strong feelings and to work out its conflict. Although the precise mechanism by which staff withdrawal leads to the development of a clique from a common-interest friendship group is not clear, there seems to be a causal connexion. It is not clear whether the patients in forming a clique are simply taking up the slack resulting from staff withdrawal or whether they are basically attempting to provoke the staff into taking greater interest in them. On an individual level, we know that the patients frequently seem to prefer a reaction, even a negative one, to lack of interest.

It is not certain how often a staff decision-making crisis such as the one described is associated with clique development. One of a patient's motives for joining a clique may certainly be to avoid having to make decisions for himself and may be a direct identification with a therapist's conflict. However, this particular decision-making problem did not seem, on the surface at least, to be operating in any but two Yale Psychiatric Institute cliques.

III. The significance of staff affective withdrawal

The importance of staff affective withdrawal seems to arise from the strong ties therapists tend to have with patients in a therapeutic community. Parsons (1951) has noted that the professional role of the doctor in society is governed by norms of affective neutrality. In psychiatric practice, particularly psychoanalysis and psychoanalytically oriented psychotherapy, the therapist attempts to behave in an affectively neutral way with the patient and to utilize this relationship in the emotional re-education of the patient. In

distinction to the psychiatrist treating out-patients, however, the psychiatrist practising in a therapeutic community has much greater difficulty maintaining an affective neutral relationship with his patients. Hospitalized patients are generally more emotionally deprived and subject to more emotional turmoil and anxiety than psychiatric outpatients. Furthermore, within the hospital, there are many pressures on a therapist from other staff and patients. Since his treatment affects other members of the hospital community, it may have an important influence on his daily relationship with work associates. This kind of pressure is more immediate than the family and social pressures on the outpatient therapist. There are many pressures on the hospital therapist from society at large, also. For example, society's expectation that the doctor will take total responsibility for the patient, including making decisions for him and about him, tends to encourage staff affective involvement rather than neutrality. Furthermore, there is still little basic understanding of mental illness, particularly the hospitalized mentally ill, and this contributes to involvement, a tendency to side with the patient against the world. With physical illness, the doctor, the patient's family and society are generally on the same side; with mental illness they may frequently be at loggerheads.

Moreover, there may be therapeutic indications for staff affective involvement with patients in a therapeutic community. The psychotic hospitalized patient certainly does not do well in the affectively neutral setting of classical psychoanalysis. In fact, it may be argued that only a therapist who is 'real', in other words, able to feel and express real emotions of anger, love, etc. to the patients, can be helpful to them.

IV. PATIENT RESPONSES:
THE SIGNIFICANCE OF CLIQUES

With such therapeutic and sociological pressure toward staff involvement, therefore, it is not surprising that staff affective withdrawal should call forth fairly strong responses from patients. Clique behaviour is probably only one of several patient group responses to staff withdrawal. Scapegoating, wherein the group displaces its hostile feelings to one member or class of members, may be another response of this type. Overt group delinquency, i.e. all degrees of antisocial behaviour including total group disintegration, may also occur as a response to staff withdrawal. These responses are obviously not therapeutically valid.

As for cliques, some of the immediate therapeutic objections have already been noted. From the point of view of long-range goals, the clique may serve to bind the patient more closely to the hospital and in that sense have a regressive function. For example, one of the members of the first Yale Psychiatric Institute clique described above made a practice of making long-distance calls to the members of the clique when she was visiting home on week-ends. On the other hand, the clique may function to help a patient move away from the hospital into the outside community. Eisenstadt has noted that in those societies which are moving from traditional sorts of authoritarian type control to more independent groups, peer groups assume an unusually great significance. In an analogous way, in our own society a peer group takes on a special importance at the time a child first enters school and in his adolescence (Buxbaum, 1945). These are both times at which he is breaking away from the traditional family control and the peer group stage functions as a very important agent in transition to becoming more independent. The clique within a hospital setting may have a similar function; as patients start to gain independence from the hospital administration, peer group activity assumes greater significance.

Another function which the clique may serve is to limit rivalry among members and to avoid pairing in sexual relationships. In the hospital situation, there is often intense

competition and sexual pairing may pose a problem both for the individuals and for the hospital as an institution. Clique behaviour is one way of controlling competitive feelings for the clique members and preventing relations from being too disruptive or too aggressive. Also, just as adolescent cliques in high school may act as group chaperones to prevent too early sexual pairing of its members, clique formation in a hospital serves the same function. The control of sexuality and rivalrous feelings was a striking feature of the first Yale Psychiatric Institute clique described above.

The hospital clique, like peer groups outside the hospital, may also function to control members from becoming too deviant. Although the peer group may accept and even encourage a certain amount of hostility towards hospital administration, it frequently does not encourage a great deal and tends, in some cases, to apply more effective sanctions against extreme hostility of members than even the hospital administration might do. Essentially, the clique fosters homogenization of the attitudes of its members.

What is the significance of clique membership for individual members? All of the therapists of patients involved in the first Yale Psychiatric Institute clique described were aware of the existence of the clique but in most cases could attribute no specific positive or negative function to clique membership as such. With a group of highly integrated patients such as the ones involved in this clique, it is certainly hard to say whether any improvement made during the time of their membership in the clique was due to clique membership *per se* or was simply a function of their general improvement during this period.

A more specific evaluation of this question may be seen in the accompanying Table 1. This table shows objective evidence of movement away from or outside of the hospital of all twenty-one open ward patients at the Yale Psychiatric Institute during the two months at which the activity of this particular clique was at its highest. The outside movement indicated consists only of activities which were carried out outside the framework of clique activities.

Whereas five out of eight hospital clique members made definite steps towards the outside community during this period, only two out of twelve non-clique members made similar steps. Although this certainly does not demonstrate that the clique was in itself responsible for this outside movement in the clique group, it does show that clique membership is not inconsistent with movement outside the hospital. After the clique broke up, in fact, only three members increased their outside movement whereas three seemed to move backwards and two stayed essentially the same without much outside movement until much later in the year.

Although it is difficult to evaluate the true effects of clique membership on individuals without a careful study of the individual's life history or without comparing several matched sets of patients at the same level of integration with and without clique membership, clique membership *per se* is certainly not universally destructive. One therapist interviewed, in fact, felt retrospectively that his patient, one of the clique members, found his way to social dating facilitated by the cloistered experience with girls in the clique. Even the excluded members of the clique might find its existence ultimately useful as a spur to an examination in therapy of their own personality trends which led to their being excluded (if this is not stretching the idea of benefit too much).

V. Conclusion

In closing, two points raised in this paper bear emphasis. First, the staff negative response to clique behaviour for five out of six cliques studied by the authors is an example of action which seems motivated primarily by sociological pressures, i.e. the smooth administration of the hospital institution. As such, it may not necessarily coincide with therapeutic goals. On the other hand,

Table 1. *Outside movement of open ward patients, December 1959 to January 1960*

Patient	Outside movement		Description
	Yes	No	
Clique			
C.A.	×		First week-end home since hospitalized
C.R.	×		Began searching for a more demanding job
C.E.	×		(1) Began Grace–New Haven Community Hospital volunteer job, and (2) signed up for auditing class at Law School
C.L.		×	No change
C.D.	×		(1) Began art class at Community Centre and (2) took trip with family for first time since hospitalized
T.A.		×	No real movement although was job hunting
S.R.	×		Moved belongings out of hospital to apartment while on day plan
S.M.		×	No change
Total	5	3	
Non-clique			
N.O.		×	Resigned from Yale
N.E.	×		Obtained apartment outside hospital
N.A.		×	No change
N.I.		×	No real change
N.G.		×	No change
N.R.		×	No change
N.C.		×	Minor psychotic regression
N.H.		×	Moved to open ward during period, but no real movement
N.L.		×	Had to be moved to locked ward temporarily
N.S.	×		(1) Moved to open ward during this period, and (2) first week-end home since hospitalized
N.P.		×	Had to be moved to locked ward temporarily
N.T.		×	No change
Total	2	10	

the necessity for staff affective involvement with patients may also be a result of sociological pressures but may, in fact, coincide with therapeutic goals in the hospital. Secondly, clique membership particularly may function to enhance pathological personality trends and increase the patient's investment in the hospital community and retard his movement to the outside community. Also, cliques may tend to undermine a unified group atmosphere in the hospital as a whole. This may be a serious therapeutic problem because a positive total group experience may be a crucial factor for ego growth in a therapeutic community. In an analogous way a positive family experience eventually allows the child to leave home and develop his own independence. However, peer groups and cliques seem important in helping the adolescent to make this transition even with a positive family experience behind him. Hospital cliques also may function to provide a relatively adequate transition to the outside community.

Finally, some suggestions might be made about clique management. The school principal type of management, i.e. clique suppression, although not necessarily therapeutic in itself, may be important to the life of the institution at times. Also, like all considerations of power and order it is one of the realities of life with which patients will

have to learn to cope. Suppression may be useful, therefore, if the staff is clear about the reasons and conveys these to the patients so that in the long run better solutions can be found. In the ordinary school situation, suppressed cliques can continue to exist outside. In a hospital, their function has to be replaced or handled in some way. Consideration of the patient's problems in individual therapy is ultimately where they are best worked out for them. However, this may not be rapid enough to suit the needs of the community. In fact, some hospital organization problems are never solved only by individual therapy. However, group interpretation, in patient–staff meetings, group therapy and other places, albeit slow also, may open up avenues of communication and allow for resolution of both the community and individual problems.

It is interesting that one of the cliques studied by the authors, an adolescent group at the Yale Psychiatric Institute, was not opposed by the staff but an attempt was made to sponsor it. This occurred in spite of the fact that this clique tended to be fairly destructive and obstructionistic. Partly the staff seemed to favour this particular clique because of some developing recognition of the basic values of clique behaviour as presented here. The primary factor, however, seemed to be that adolescent clique behaviour is usually acceptable in society at large.

In general, staff sponsorship of clique behaviour might be one way to curb the clique's destructiveness and yet allow some of its benefits for individual members. It has its problems, however, because staff sponsorship frequently can be the kiss of death to any patient venture, especially one focused around hostility to authority. Still another possibility is to allow the clique a fair amount of independence and only to attempt to control it when it is antisocial or particularly obstructive to hospital organization. In any event, the authors feel that clique formation should not be considered *a priori* destructive and a careful consideration of the impact of a particular clique on the therapeutic community should be made before any action is taken.

REFERENCES

BOYD, R. W., KUGILES, S. S. & GREENBLATT, M. (1954). Outbreak of gang destructive behavior on a psychiatric ward. *J. Nerv. Ment. Dis.* **120**, 338–342.

BUXBAUM, E. (1945). Transference and GP formation in children and adolescents. *The Psychoanalytic Study of the Child, vol.* I, 351–65. New York: The International University Press.

CAUDILL, W. (1958). *The Psychiatric Hospital as a Small Society.* Cambridge: Harvard University Press.

DENBER, H. C. B. (Ed.) (1960). *Therapeutic Community.* Springfield: Charles C. Thomas.

EISENSTADT, S. N. (1956). *From Generation to Generation: Age Groups and Social Structure.* Glencoe: The Free Press.

FLECK, S. (1962). Residential treatment of young schizophrenics. *Conn. Med.* **26**, 369–76.

JONES, M. (1953). *The Therapeutic Community.* New York: Basic Books.

MILLER, D. H. (1957). The etiology of an outbreak of delinquency in a group of hospital adolescents. In *The Patient in the Mental Hospital*, pp. 427–34. Ed. Greenblatt, T., Levinson, D. J. and Williams, R. H. Glencoe: The Free Press.

PARSONS, T. (1951). *The Social System.* Glencoe: The Free Press.

REDL, F. (1959). The concept of a 'therapeutic milieu'. *Amer. J. Orthopsychiat.* **29**, 721–36.

REDLICH, F. & HOLLINGSHEAD, A. B. (1958). *Social Class and Mental Illness.* New York: Wiley.

STANTON, A. H. & SCHWARTZ, M. (1954). *The Mental Hospital.* New York: Basic Books.

Social ramifications of the therapeutic community approach in psychotherapy*

By RICHARD CROCKET† AND RONALD ST BLAIZE-MOLONY‡

The definition of the phrase 'therapeutic community' is still not quite clear. Main (1945) first used the phrase, but did not at that stage attempt a definition. Jones (1952, 1959) who had so much to do with the early exploration of community group methods of treatment, discussed it in terms of all the resources of a hospital being used for therapy during the whole 24 hr. of the day, so that staff are necessarily aware of their psycho-therapeutic roles at all times. In more recent years, as awareness of the social significance of the concept has spread, the question of definition has been side-stepped, and workers in widely differing types of therapeutic units have proceeded with the development of their own experiences of social group therapy (Caudill, 1958; Denber, 1960; Meijeering, 1955; Rapoport, 1960; Wilmer,'1958).

If, as a result of experience in the field, a definition is eventually widely agreed upon in retrospect, it will imply that one knows with some precision the ways in which a community is helpful to the individual. It should then be possible to use as a measure of the natural communities of society a dimension not much considered up to now, namely their value for the achievement of human fulfilment, or at least, support, in the internal struggle of the individual with his human predicament.

In this paper, the notion of the 'therapeutic community approach' to treatment, is taken to imply that the significant therapeutic relationship is between the patient and the community

in which he is treated, rather than between the patient and any individual therapist. The skill of the therapist is to maintain this position, and the methods employed are regarded as a highly specialized clinical administrative procedure. (Crocket, 1960).

Details of the therapeutic community at the Ingrebourne Centre have been published elsewhere (Crocket, 1961, 1962). It is similar to that developed by Maxwell Jones at Belmont Hospital, and makes use of carefully structured and integrated community and staff meetings, through which problems of patients and staff alike can be brought into general discussion.

The effects of this adaptation of the hospital unit are complex. They can be described in different ways, and at different levels of psychotherapeutic sophistication. For the therapist, however, the essence of the resultant situation is that he experiences in both large and small ways, an on-going challenge by the community to display his capacity for permissiveness. The community transactions, which may be communicated both verbally and in behaviour, tend steadily to become more anxiety-provoking for the therapist. There is usually an accompanying tendency for him to respond by exercising authority, rather than unwillingly to continue an appearance of identifying with what he judges to be an errant position; but it is only when the therapist is skilled and experienced enough to allow control to develop through the community transactions themselves rather than through the exercise of his clinical administrative authority that the true community relationship develops. However, reasons for the exercise of any authority are always more apparent in a smoothly functioning therapeutic group, so that even when the

therapist does on occasion feel constrained to resume some of his delegated authority his actions are usually understood and accepted by the community.

COMPARISONS BETWEEN THERAPEUTIC COMMUNITY AND SOCIAL GROUP

These observations are couched in somewhat assertive terms, at this stage, without elaboration, since it is intended to proceed now to speculation about the relationship of such therapeutic community transactions to similar social group activity, such as may be found in non-medical professional circles, and in comparable social milieu. Our aim is to establish conceptual understanding of possible similarities in organization and significance in these other social groups, and to consider whether clinical psychotherapeutic value can be expected to attach to them.

Grounds for believing that this may be so arise in at least two respects; the first being sociological, and the second clinical. Regarded objectively, all populations are clearly self-organized into subsidiary groups which are mutually interactive, and which all possess some features of almost universal distribution. The basic biological group for example, is the family; and from the point of view of the social psychologist other social group formations—working, religious, recreational, and so forth—although very diverse in their overt purposes, often tend to reproduce the relatively primitive reactions of family relationships, or to provoke a milieu in which family surrogate relationships can be readily recognized. A clinical group, structured for therapeutic purposes, is no different in this respect; and a verbalizing therapeutic community always quickly becomes aware of this fact, and hands this awareness on to succeeding generations of patients.

The second reason amounts to the same observation made from a different angle. If groups are allowed to develop interaction on permissive lines, even when their overt purpose is not therapeutic, or even in any remote sense clinical, exactly similar transactions quickly develop as in therapeutic groups; and the only way in which this can be avoided appears to be through the use of intellectual intervention, with the exercise of didactic authority, either deliberately or on the basis of the group leader's own personality needs.

At the Ingrebourne Centre two such non-clinical groups have been under way, in 1962, in the one instance for three years, and in the other for four years, on a fortnightly basis. One group is made up of four clergymen, together with about the same number of staff; and the other of about ten probation officers, meeting with one psychiatrist. A third field of observation has been educational, in that the senior clinician in the Centre has for some years acted as visiting psychiatrist to two schools, one for maladjusted boys, and the other for intelligent delinquent boys, both schools being relatively authoritarian in their professional outlook, and both exploring the place of group interaction in their professional organization. It is intended now, without going into detailed exposition of experience with these non-medical groups, to formulate some general comment which may indicate the conceptual trends at present in mind.

COMMON FACTORS IN COMMUNITY GROUPS

The importance of authority roles in the therapeutic community has already been mentioned. Their importance also provides one of the major elements common to all the small community groups under consideration —family, education, religious, working and so forth. The existence of such roles derives from the need for the disposal in some way or another of authority feelings on the part of the individual participants. The hypothetical question which seems to arise is whether the characteristic of the therapeutic community approach in psychotherapy which may conceivably bring a therapeutic element into the functioning of these social groups may not lie in the means by which such authority roles are given expression.

This shows perhaps most clearly in the educational groups. Scholastic method in all

countries tends to be authoritarian, and to give priority to didactic instruction: but from time to time occasional 'progressive' groups develop, mostly on the basis of an intuitive skill or capacity on the part of one particular individual. Such 'progressive' schools, or community groups, to use our present terminology, are practically always more permissive, in the psychotherapeutic sense, than their much more numerous orthodox counterparts. And it is striking that permissiveness of this kind is acceptable mostly in terms of caring for difficult and maladjusted children. The analogy with the therapeutic community is obvious.

Similar concepts can be applied to other groups, although not always with such clear-cut clinical relevance. Religious groups might be considered to rival educational groups in potential social therapeutic significance, however, in that they make use of relationships of a close and intimate kind which have straightforward family surrogate significance, and which also pervade all groups in the population. This is not the occasion for examination of the complex question of the connexions between religious belief (or agnosticism) and mental health. But belief is a reality for many people, and it is natural and inevitable that ministers of religion and members of the priesthood will on many occasions be the first professional figures presented with an opportunity to bring social therapy to bear in individual emotional problems. Moreover, the regular voluntary group interaction associated with religious practices may clearly have significance of the kind recognized as important in therapeutic community practices also.

An example of how the same sort of dichotomy has appeared empirically within a religious body may be found in the society of St Vincent de Paul. This is an organization devoted to the relief of poverty, but its primary stated aim is the spiritual elevation of its individual members. Again, the practices of the Society of Friends have remarkable similarities to those of the Ingrebourne Centre.

THE DIMENSIONS OF SOCIAL GROUPS

Questions of this kind lead to consideration of the dimensions of social communities, since their quantitative definition is a prerequisite for accurate classification. Some dimensions are straightforward. Size, in terms of numbers; duration of contact, in terms of the length of a continuing relationship; frequency of meetings; the definition of the overt social purpose of the community concerned—all such factors can be readily assessed. With experience in the application of a sociological conceptual model of this kind more subtle differences gain a topical importance when set against modern socio-cultural flux. People now lose old ties abruptly and have an urgent need to develop skill in abstracting new supports from their work, and from neighbourhoods often unfamiliar, and, at least superficially, unfriendly. Furthermore, the society which follows individual upheaval of this kind tends to be structured increasingly by social legislation. The means of adjustment within such an organization-orientated way of life tend to be very different from those of the rugged Victorian individuals who first were in a position to avail themselves of formal and deliberate clinical psychotherapeutic help.

Even now, however, social agencies which at first sight appear to be quite unlike therapeutic communities can be shown to fall within the same conceptual framework. For example, a magistrates' court in England, which is a police court dealing with minor offences, bears little superficial resemblance to a hospital unit. But from the social therapeutic point of view there are striking similarities, the differences indeed being in the quantitative aspects of the community dimensions rather than the qualitative. Thus, the court has its leader, or therapist, its staff, and its routine. It meets regularly in group sessions. It makes use of ritual procedures, which have a deep traditional derivation within the culture of the population it serves: and all such practices can be equated with the

structuring of an artificial medical therapeutic community. Its clients, patient equivalents, receive attention for behaviour which is very often indistinguishable from that of the emotionally maladjusted—such as, for example, compulsive petty thieving, repetitive drinking, outbursts of irrational aggression, sexual aberration, and so forth. The magistrate will often admonish the client, and attempt to persuade him to change his ways, delivering what amounts to an authoritarian homily aimed at giving the subject insight into what the future holds for him if he does not adapt. A proportion of the court's clients are even accepted, with some resignation, as incapable of change, and it is perhaps not too fanciful to suggest that their more or less regular appearance simulates routine attendance at hospital for supportive psychotherapy. Finally, we see, in Britain at least, a definite move towards social therapy in the provision of a probation service under the aegis of the courts, a service which is becoming increasingly trained and skilled in the techniques of relationships, and, perhaps especially significant, is increasingly providing a service which can be used by many individuals in distress for social and personal guidance *before* any question of attendance in Court arises.

SCOPE FOR SOCIAL APPLICATION OF THERAPEUTIC COMMUNITY EXPERIENCE

This latter point underlines the nature of the importance of the similarities between our new therapeutic community procedures in medicine and the intuitively established procedures of the non-medical sociological groups. It is in the potential prevention of emotional disability that social ramifications of such clinical work can conceivably be fully justified. Preventive psychiatry and the aims of positive mental health in fact appear to find common ground in these social groups. The questions which speculation of this kind seems to raise for discussion at this stage, are, first, to what extent is it practicable and, secondly, to what extent is it desirable, to try to achieve wider dissemination of permissive and interpretive skills, using social networks and community relationships of the kind described. Can it be done within the discipline of social science? And if so can it effectively influence the irrational forces which at present seem to pervade all human interrelationships even to the extent of self-destruction? Such wider perspectives bring an element of excitement into what is now the relatively mundane application of therapeutic community principles in day-to-day social psychiatry.

REFERENCES

CAUDILL, W. (1958). *The Psychiatric Hospital as a Small Society.* Cambridge, Mass.: Harvard University Press.

CROCKET, R. (1960). Doctors, administrators, and therapeutic communities. *Lancet,* 2, 359–63.

CROCKET, R. (1961). The Ingrebourne Centre, Hornchurch. Treatment and its Results, 1957–59. North-East Metropolitan Regional Hospital Board, London.

CROCKET, R. (1962). Initiation of the therapeutic community approach to treatment in a neurosis centre. *Int. J. Group Psychotherapy,* 12, 180–93.

DENBER, H. C. B. (1960). *Research Conference on Therapeutic Community.* Springfield, Illinois: C. C. Thomas.

JONES, M. (1952). *Social Psychiatry.* London: Tavistock Publications.

JONES, M. (1959). Towards unification of the concept of a therapeutic community. *Brit. J. med. Psychol.* 32, 200–5.

MAIN, T. F. (1945). The hospital as a therapeutic institution. *Bull. Menninger Clin.* 10, 66.

MEIJEERING, W. L. (1955). *On Community Psychotherapy.* Utrecht: Smidt.

RAPOPORT, R. N. (1960). *Community as Doctor.* London: Tavistock Publications.

WILMER, H. A. (1958). *Social Psychiatry in Action: A Therapeutic Community.* Springfield, Illinois: C. C. Thomas.

The ward as a therapeutic group

By J. K. W. MORRICE*

For many years it has been possible to divide psychiatry into two broad schools, organic and psychological. Most British psychiatrists have probably sat comfortably or uncomfortably in between, under such designations as eclectic or multi-dimensional. However, the two extremes are easily recognizable. Now a third faction, perhaps originally a development from the analytic school, has appeared and is recruiting from both sides. This is social psychiatry. The social psychiatrist finds that he cannot usefully view the patient apart from his milieu; that the comprehensive investigation and treatment of mental illness raises issues more clearly recognized perhaps by sociology and anthropology than by traditional medicine; and that the social adaptation of the patient in hospital and in the outside community is the main challenge. Treatment methods emphasize the group approach with a democratic organization in the ward and hospital.

In psychiatry, as in any endeavour where there is both fervour and doubt, the people engaged tend to feud with one another and forget that it is honestly possible to come to different conclusions in the face of the same apparent facts. May be psychiatrists should live more and talk less. However, the use of ridicule is tempting—for example, the stigmatizing of the organic school as no-think, instant psychiatry; or the labelling of social psychiatry as a form of happy families where the staff's problems become so urgent that the patients have to treat themselves. Unfortunately criticism within the speciality may lead (and indeed has led) to an entrenchment of opinion and practice. With regard to social psychiatry, its aims and methods,

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we need much more information so that full evaluation can be made, remembering that every patient for good or ill is reacting to some sort of environment.

Terms like therapeutic community, administrative psychiatry, milieu therapy and community treatment are used frequently but they have different meanings for different people. Clark (1963) in a historical survey of this area draws many threads together and concludes: 'After rediscovering the methods of moral treatment, after making our patients active, and then free, we are now beginning to study the applied social psychology of hospital administration and beginning to construct communities where the express purpose is rehabilitation and the social structure consciously engineered towards this'. It is in this sense that the present paper discusses some aspects of social psychiatry at ward level.

THE WARD MEETING

A keystone of the therapeutic community is the ward meeting. Ideally this occurs daily and includes all patients and staff who are able to attend. The meeting lasts about an hour and is followed by a 'post mortem' involving staff members only. The value of this arrangement has been discussed by Jones (1962) and Jones & Hollingsworth (1963). It provides at one and the same time a therapeutic method of dealing with patients' problems and an effective way of teaching social psychiatry to staff in a living situation. In fact patients and staff learn together.

What happens in the ward is really what happens in the hospital at large, although events may be taking place at varying intensities and at different levels with different patient-staff groups. The individual ward is

where a beginning must be made in evolving a therapeutic community in a psychiatric hospital of any size. It seems valuable therefore to consider the ward situation from the points of view of patient, nurse and psychiatrist.

PATIENT

The first question usually is: Which patients and how many attend the ward meeting? According to Jones & Hollingsworth (1963) it is possible to accept up to 80 patients in a group of this sort, although some therapists might think it difficult to be aware of the interaction of so many different personalities. There is certainly much to be said for using the whole ward as the treatment unit. My own experience in dealing with a ward group of some 30 patients has convinced me that this is a feasible and worthwhile project. Perhaps the size of the ward, and consequently the size of the group, should be decided by the nature of the patients and the aims of the therapist. It is true that one cannot manage a large ward meeting in the same way as a small group of selected patients. But there is great value in all patients in the ward meeting together. Since they live with one another day by day, they meet common problems and these provide material for group discussion. Of course it is not always practicable to include everyone. A patient may be physically ill and confined to bed; he may be so confused, demented or disturbed that his inclusion disrupts the group. Yet it is surprising how easily patients in an admission ward accept and understand the delusions of an acute schizophrenic, the restlessness and overtalkativeness of the hypomanic and the lack of judgement of the dementing senile. Valuable material may be obtained from a patient at the height of his acute illness which is suppressed a few days later. The admission ward that takes 'all-comers' may nevertheless find it useful to exclude the deteriorated patient from the group meeting, the decision being made openly. (Ideally, acute admission wards should not contain deteriorated patients, but in reality they often do.)

If a patient does not wish to attend a group meeting is he persuaded? And if he attends but takes no part what then? These are practical issues that continually affect patients and staff and they may be difficult to resolve. In general it can be said that patients are motivated to attend and participate by their curiosity or emotional tension or their desire to conform to staff wishes. The valuation which staff put on the meetings is apparent to the patient who will not willingly or eagerly attend if, for example, the ward-sister implies that the groups are time-wasting and upsetting. On the other hand, if staff and other patients show that they value the group meetings highly, consider them part of treatment and expect to attend as a matter of course, full attendance is likely.

How far patients avail themselves of the group situation to reveal their problems is once more largely a result of what the staff expect. But there is no doubt that some patients find difficulty in full participation. The social psychiatrist looks upon the illness of his patient as a social disease in the sense that there has been a breakdown in living with others (in communicating, earning and so on). The patient has to recognize this and relearn old skills or learn new patterns. This is best done in a living–learning situation which means relating to others in a group. But some people set a high value on keeping themselves to themselves. They feel uncomfortable and even shocked at the 'open confessional' of the group meeting and consider it embarrassing or even unthinkable to reveal personal or family problems. Of course people tend to find in their environment what they are disposed to find. The woman who sees neighbours as friends will find it easy to make friends in the ward; the woman who sees a threat in everyone she meets is perhaps all the more likely to enter a psychiatric hospital and find threats there too. She will not experience the group meeting as a heaven-sent chance to talk about herself and

live through her problems, even although she needs this more than most. What then do we do with her? It is possible to some extent to overcome a patient's reluctance to talk by giving explanation and reassurance. Emphasis may be laid on the fact that fellow-patients are not the public at large; that the group is composed of patients with similar difficulties, nurses, doctors and social workers who are skilled in understanding; and that this provides a potent therapeutic machine at each patient's disposal. One may arrange circumstances in such a way (e.g. by discouraging individual interview) that the patient's problems become urgent and willy-nilly he brings them to the group. It is after all a person's drive to reduce tension, his desire to become whole and efficient, that makes him face and perform unpleasant tasks. It may be legitimate therefore to keep high the patient's motivation to use the group situation. This may mean the avoidance of drugs or individual psychotherapy which would reduce his tension, make his situation tolerable and him lazy in meeting his real difficulties. How far one may go in this direction and remain comfortable and ethical as a doctor is arguable. A therapist may be uneasy if he feels a patient is being pushed against his will to talk in the ward group; each case of this sort may have to be dealt with on its merits. Many psychiatrists, while encouraging all their patients to make full use of group meetings, will find it necessary to provide in addition individual sessions, drugs and other physical treatments.

Taylor (1961) has pointed out in this connexion: 'In a therapeutic group embarrassing confessions are made to people who might gossip even though they know that discussions should be confidential. Leakage of information is a particular hazard where patients live in small communities in which social and occupational areas overlap. There is a danger that their reputation might suffer through gossip, rumour, tactlessness or ill-will'. He goes on to say, however: 'In

groups which achieve stability the basic confessional task soon becomes established and honoured'.

It is worth remembering that all groups are not therapeutic. Particularly with an unskilled leader or unsophisticated staff, a ward group may aid and abet a patient in harbouring his private neurosis. Where the 'ego strength' of the group is low, an individual patient may use the group situation as a sounding-board for grievances or manipulate his fellows to suit his needs—e.g. remaining over-long in hospital 'to get right to the root of my trouble' or leaving precipitately 'because my family need me'. His real problem lies undisturbed and may become subtle and refined. This is not so much a criticism of the method of groups as a warning against abuses of it.

It is well to admit, however, that at this stage of development the whole question of selection of patients for group treatment and the nature and task of the group is still under investigation. We tend to select patients by their traditional labels of clinical diagnosis and then pitch them into group situations where their individual reactions may be hidden. It is quite possible that the group emphasis on verbalizing is unsuitable for some. As Rapoport (1960) suggests, verbalizing comprises a small proportion of the daily life of the ordinary British working man, who may have difficulty in sustaining involvement in the group. In this respect, work done in the Department of Corrections, California (Sullivan, Grant & Grant, 1957; Grant & Grant, 1959) is important because it proposes that patients may be selected better on the basis of social maturity or what the investigators call integration levels (I-levels). The better the I-level the greater the capacity to form social relationships and to perceive self and environment without distortion. As Jones, Briggs & Tuxford (1964) have commented, it may well be that I-levels give a superior method of selection of 'treatment units' of patients compared with conventional classifications. Moreover, the I-levels of nursing

and ancillary staff might profitably be matched with patients' in a suitable treatment situation.

Nurse

A therapeutic community offers tremendous possibilities for the psychiatric nurse who has the abilities and interest to become a full member of the therapeutic team. It is also true that the nurse working in a ward which has been run on traditional, authoritative lines and which is then turned over to the new task of milieu therapy will feel at first confused, anxious and resentful. Martin (1962) has clearly described his experience in the promotion of a therapeutic community at Claybury. He has pointed out how dependent are the nurses in a traditional mental hospital upon its authoritarian structure. Since their main task is seen as custodial and their efficiency measured by the peace and tidiness of the ward, little emphasis is placed upon the nurse–patient relationship which remains on a basis of authority and submission. In fact everyone's relationships to everyone else are governed by formal rules which maintain status and security.

It is easily surmised how much upset is caused by removing this rigid authority system and replacing it by a flexible, spontaneous and human approach where official status does not protect from criticism. Indeed it is folly to attempt to introduce such new concepts and behaviour without full discussion beforehand; and a warm and continuing relationship between medical and nursing staff is necessary to ensure free communication whereby staff anxiety is dealt with before it explodes. As the new system expands and nurses and patients find the advantages of freedom with responsibility, trust also grows (albeit slowly) and allows further steps to be taken without undue alarm. However, it appears unavoidable that some nurses become extremely anxious and angry. For example, the older nurse may have become set in his ways and resents new methods that overturn his well-tried routine. A ward sister may feel that her hard-won experience of nursing techniques is devalued and her status and even her job is in jeopardy. Some nurses may be alarmed at the new-found freedom of patients to express and conduct themselves and feel unsure of how and when to exert restraint over misconduct and disturbance. Step by step, however, the social structure of the ward changes to foster the aims of a truly therapeutic situation. In such a culture, where staff and patients all have a contribution to make towards therapy—putting all their egos in one basket, as it were—there is an overlap and a blurring of roles. The traditional place of psychiatrist, ward sister, junior nurse, psychiatric social worker, kitchen supervisor or gardener may be quite altered. An assistant nurse may reveal and develop such an understanding of group psychology as to be in practice a better therapist than charge nurse or doctor. Patients may become fit to adopt roles traditionally reserved for nurses, and so on. While such changes satisfy some they raise tensions in others. They have to be resolved and this is best done in the staff meeting which follows the ward group meeting. In this setting many problems can be ventilated, placed in perspective and sometimes solved.

This staff meeting, which carries over from the ward meeting much of its atmosphere, provides a very necessary opportunity to examine the perceptions, emotions and interactions of staff and patients. Anyone with experience will agree that ward meeting and staff meeting frequently mirror one another. For example, if nurses are finding it difficult to communicate at their staff meeting, it is likely that the patients' group has been, and will be, marked by silences and superficial talk. The 'post mortem' does not concern itself only with the conduct of the ward group, however. It is also, in a sense, the staff's 'treatment group' where anxiety and frustration can be revealed and understood. Here it is that the charge nurse shows his alarm over the ward's state of untidiness, 'because nurses

and patients spend too much time at meetings these days'. Here the Assistant Matron may reveal her displeasure at the apparent encouragement of sexual licence between male and female patients. And here is also the opportunity for staff to learn that a patient's untidiness may be a form of communication, that an aggressive outburst may be used as a learning experience, that conduct may be examined without rancour, and that responsibility shared is anxiety reduced.

Nurses may find that the policy changes engineered by the senior staff of the ward or the hospital are out of keeping with their own behaviour-patterns and personal beliefs. They may find consequently that certain situations are alarming and that they are inefficient in dealing with them because they have failed or refused to assimilate the new approach. Sexual and aggressive behaviour between patients is a potent source of anxiety in this way and it is not uncommon for nurses to project into the situation their own unconscious fears and fantasies. If a staff member finds it impossible to accept milieu therapy as a way of working, then there seems no alternative but to leave that ward or hospital for one with a more traditional régime. There is no doubt, however, that despite initial stresses staff do learn to gain more satisfaction at seeing a patient solve a problem than solving it for him. They come to see how important it is to allocate to patients every task suitable for them, for in essence the therapeutic milieu is the one which provides culturally relevant problems. This may well mean that patients take over the household duties of the ward and that the sexes mix at work, socially and in treatment groups. It is also true that, even with dawning insight and new interest in his role, the nurse may find difficulty in exchanging a relatively simple and structured relationship for a complex, vaguely defined one. The psychiatrist must provide support in this transitional period and be prepared for buffeting and hostility. He should keep clearly before himself and his nursing colleagues the belief

that the tensions evoked by the new régime are worthwhile and purposeful because their resolution is constructive and leads to growth.

Apart from ward and staff meetings, the nurse may find himself in a number of other groups, e.g. working with patients in a ward or hospital project like making a tennis court, or helping patients to arrange and conduct a dance or concert. Being in close and informal contact with the patient in this way may throw the nurse into a sticky problem of transference and counter-transference and in addition he must beware of being put in a corner by accepting privileged communication from a patient. In other words the nurse should avoid placing himself in a position where he forfeits the support of his staff-group. His tasks and difficulties are only tolerable because he does not face them alone but is able to communicate, spread responsibility and learn. Working in this fashion he not only helps his patients to deal with their problems, but also grows in stature himself, becoming more and more skilled in role relationships.

PSYCHIATRIST

It has been assumed that the leader of the ward therapeutic team is the psychiatrist. In fact this may not be so and there is no good reason why the therapist in charge should not be nurse, psychologist or social worker. However, in the beginning the role of innovator generally falls to the psychiatrist. He by virtue of experience and training, acts as guide towards the democratic organization of the ward which is necessary for the implementation of milieu therapy. It is the paradox of democracy that to be efficient it needs good leadership.

How far milieu therapy can be successful in one ward of many in a psychiatric hospital is arguable. It may depend on the size and structure of the hospital and the extent to which the individual psychiatrist enjoys autonomy. Undoubtedly the new ward culture will impinge upon the rest of the

hospital and the attitudes of colleagues, Physician Superintendent and Board of Management are important. It is very difficult, if not impossible, for the organization of one ward or unit to be democratic and permissive if the lives of other patients in the hospital are governed by formal regulations. The ward engaged in milieu therapy will find itself in these circumstances ostracized, misunderstood and resented unless other senior medical and nursing staff (at least) are fully aware of the position and are sympathetic to it. Perhaps one should hesitate to embark on the venture at all unless it seems likely that the new culture will spread over all.

The ward run as a therapeutic community throws up endless daily problems that are looked upon traditionally as administrative rather than clinical. The social psychiatrist must accept that much of his day is spent in dealing with such matters which are the raw material of therapy. He therefore spends many hours per week in groups and meetings of patients and staff and this can be time-consuming and sometimes apparently slow and inefficient. This is true of all democratic organizations. But it is certain that decisions which are group decisions are much more likely to be accepted and put into effect wholeheartedly; so in the long run efficiency is achieved.

The ward organization described cuts across the accepted hierarchical structure of traditional medicine and for the doctor, as for the nurse, it imposes stresses that have to be recognized and met. It is novel, for example, for the consultant in charge of a ward to be open to criticism by his patients, junior colleagues and nursing-staff. Statements are no longer right simply because he makes them. His actions are commented upon and his treatment methods queried. This may be intolerable for some and milieu therapy is not for them. But for those who have long felt that the potent influence in hospital is the person in close daily contact with the patient the inclusion of nurses and patients in the therapeutic team is inevitable. This does not

mean that the psychiatrist abrogates his authority and that ward life becomes liberal to the point of confusion with no limit set on aggressive or deviant behaviour. On the contrary, it is very necessary for the psychiatrist to give firm and unambiguous leadership. A framework is clearly established within which the life of the ward takes place. This does not imply regimentation, but it does require acceptance of a common cultural standard and ideology. To treat patients permissively is to invite behaviour which is designed to test limits or avoid responsibility. Staff come to deal with this as a living-learning situation; not as an occasion to exert discipline or inflict punishment, but rather as an opportunity to gain deeper mutual understanding and therefore control. The goal is freedom with responsibility and to this end patients are given as much of both as they are capable of handling. The central concept is of a group of patients and staff acting together as a team or family, where weaker members are supported and responsibility and worry are shared. The epitomy of this is the ward group meeting and the 'post mortem' where, as already described, differences of opinion are recognized and a common policy agreed.

It has been said that no doctor is much of a healer unless he possesses quite a lot of witch-doctor in his nature. There may be truth in this assertion. Certainly our patients are not ill for particularly logical or 'scientific' reasons and treatment methods should recognize this. Group therapy may have its magic and psychiatrists are not called trick-cyclists and headshrinkers for nothing. On the other hand, it is necessary for the therapist to behave in relation to his patients like an ordinary human being and as naturally as possible. He may well admit his own faults and failings; he avoids jargon and tries to communicate in a simple way; and he does not attempt to hide his personality behind a mask. In a therapeutic community the mask is bound to slip in any case and the psychiatrist, by showing his willingness to reveal

himself, is giving the patients and staff great encouragement to do likewise.

The tone of the ward is generally set by the psychiatrist in charge of the programme and the therapeutic milieu will vary according to the personality and aims of the staff engaged on it. There may be considerable difference from one unit to another in the degree of 'permissiveness' allowed and in the use of E.C.T., drugs or small therapeutic groups. However, all therapeutic communities aim to develop a close approximation to normal living and working conditions and, in order to achieve this, the psychiatrist may find himself involved in the alteration of many established traditions of hospital life. For example he may have to consider whether occupational therapy in its customary form is truly rehabilitative; a work programme with realistic financial rewards may be necessary; patients may wish to plan not only their own entertainments and outings but also the purchase of their clothing and the content and timing of their meals. This brings the psychiatrist out of his ward and involves him in relationships with many of the ancillary staff and outside shopkeepers and employers. This is all to the good of course since social psychiatry aims to leave behind the concept of treatment in hospital as a goal in itself; it views the patient's stay in the ward as merely one phase of a problem that requires staff to move out of their set hospital roles into the outside community, together with the patient, to help in his resettlement.

PROS AND CONS

(1) Critics of therapeutic communities argue that they provide a culture which is false and which does not help the patient in his real life problems outside hospital. It is unlikely, they say, that a patient will ever again encounter people who seek persistently to understand his behaviour rather than react with conventional sanctions. Rapoport (1960) in his survey of what is now Henderson Hospital found that those patients who had most obviously accepted the Unit's values showed the least satisfactory adjustment after discharge. There is some doubt regarding the validity of these findings, based as they are on questionnaires to patients and staff. However, they must raise a query in the minds of milieu therapists: Are we in fact perpetrating a deviant subculture?

It may be said in defence that the therapeutic community is at least nearer real life than the custodial institution and by its methods it may persuade the patient to accept responsibility for his own behaviour and develop better patterns to carry over to the outside environment. The ward provides a transitional situation whose goal is the discharge of patients not the formation of a permanent subculture. As Cumming & Cumming (1962) point out, a well-developed culture contributes the opportunity to learn roles in a context that resembles outside life. This is why a man does carpentry or a woman housework rather than conventional occupational therapy. As the patient day by day solves his relevant problems, so his ego develops in its organization, identity and strength. He leaves hospital strong enough to work out his own compromises, or so we hope. An adequate after-care programme should then go far to prevent relapse.

(2) Another criticism is this: If the primary goal of treatment is the prompt return of the patient to a productive life in the community, how much influence on a patient's outlook and personality can milieu therapy achieve in a short time? Is it not preferable to use the techniques of a therapeutic community when dealing with character or personality disorders and treat short-term admissions with quick methods like tranquillizers and E.C.T.?

It is true that a large proportion of newly admitted psychiatric patients can be treated by modern physical methods alone and be discharged in a few weeks apparently well. But the high relapse and readmission rates cast doubt on the effectiveness of these measures. There is no easy answer to this problem. Experience informs us that to

effect a basic change in a person takes months or years; what a therapeutic community may accomplish in weeks must be small. Yet, at the very least, the social psychiatrist is attempting planned patient management which will enhance the effectiveness of any of the more specific treatment methods. And, in addition, by mobilizing the social forces in the environment he is recognizing and utilizing a new treatment dimension.

(3) A criticism that often accompanies the former is that, in the therapeutic community, physical methods of investigation and treatment are devalued.

I think it is true that one may use physical methods of treatment too little as well as too much. Some psychiatrists have found it possible to discontinue the use of E.C.T., sedatives and similar drugs. Others feel that even now there are patients in psychiatric hospitals vegetating in a kindly but inactive régime who would respond favourably to vigorous physical treatment. There is a middle way between neglect and overdependence on physical agencies and it is not suggested that a treatment unit should do other than mobilize all relevant skills. It is stupid and cruel to allow a patient to suffer a deep depression which may be quickly relieved by physical treatment; but it may be equally neglectful to use pills or E.C.T. to cut short a problem which needs to be faced in full, and by so doing prevent communication between patient and therapist.

(4) It is suggested that, while in the past we may have treated the patient too much as an individual apart from his environment, now in the therapeutic community we risk losing the individual in the mass. Conformity to group culture becomes synonymous with good adjustment and yet the patient may harbour severe problems that are ignored. It is unjustifiable to place great emphasis on conformity or on the principle (attacked by Whyte in 'The Organization Man') that disagreement indicates personal emotional problems requiring understanding and treatment. Certainly the prevailing view in any society

should not have the force of sanctity, nor should the non-conformist be abused. The therapeutic community upholds governing principles and asks for conformity to them—but they are liberal concepts like democratization, permissiveness, communalism and reality confrontation (see Rapoport, 1960). It is in just such an organization that traditionally sanctioned behaviour comes in for scrutiny and prevailing views may well be upset and abandoned if they are shown to be wrong or inefficient. It is perhaps only in a therapeutic community that each individual is encouraged to ask himself and his fellows why they do what they do. Surely there is less chance of a patient's individuality being lost in such circumstances than in the stereotyped and faceless régime of the custodial institution?

(5) A final criticism, voiced more from within than without social psychiatry, is the lack of evaluation of therapeutic communities. There is need for a set of concepts that embrace the interactions of personality and environment.

This is true and social psychiatry shares this criticism with other schools. It seems to be difficult to appraise with accuracy the results of psychiatric treatment. This should not stop our trying. Cumming & Cumming (1962) have attempted a systematic analysis of ego and milieu interaction. They suggest that, since milieu therapy sets out to make social changes and trusts that ego growth will ensue, and since social attributes are measurable, the successes and failures of social psychiatry may be easier to assess.

At the present time no school of psychiatric thought can demonstrate superiority in treatment results and there is room therefore for many different approaches. Treatment should be patient-orientated, however, and directed by the patient's needs not the preconceived notions of therapist or institution. In this case we cannot ignore the new knowledge presented by the social sciences and the challenge of social forces in the treatment situation.

SUMMARY

Social psychiatry in Britain is emerging as a new school of thought. Practised as community therapy it brings an important treatment dimension to bear. Its advantages and failings at ward level are discussed from the standpoints of patient, nurse and psychiatrist. The character of a ward (like that of an individual) unfolds and develops in response to a succession of crises. These lead to stress, but they also have positive effects in maturation. Milieu therapy uses this concept in planned patient care. Further assessment of results is needed.

REFERENCES

CLARK, D. H. (1963). Administrative psychiatry 1942–1962. *Brit. J. Psychiat.* **109**, 178–201.

CUMMING, J. & CUMMING, E. (1962). *Ego and Milieu.* New York.

GRANT, J. D. & GRANT, M. O. (1959). A group dynamics approach to the treatment of non-conformists in the navy. *Ann. Amer. Acad. Polit. & Soc. Sci.* **322**, 126–35.

JONES, M. S. (1962). *Social Psychiatry.* Springfield.

JONES, M. S., BRIGGS, D. & Tuxford, J. (1964). What has psychiatry to learn from penology? *Brit. J. Criminol.* **4**, 227–38.

JONES, M. S. & HOLLINGSWORTH, S. (1963). Work with large groups in mental hospitals. *J. Indiv. Psychol.* **19**, 61–8.

MARTIN, D. V. (1962). *Adventure in Psychiatry.* Oxford.

RAPOPORT, R. N. (1960). *Community as Doctor.* London.

SULLIVAN, C., GRANT, J. D. & GRANT, M. O. (1957). The development of interpersonal maturity applications to delinquency. *Psychiat.* **20**, 373–85.

TAYLOR, F. K. (1961). *The Analysis of Therapeutic Groups.* London.

A longitudinal study of psychomotor functioning in acute psychiatric patients*

By J. H. COURT†

INTRODUCTION

While there is a wealth of literature reporting work on various psychomotor tasks, both in experimental and clinical settings, it is of interest to note how much the clinical investigations have been concerned with chronic patients, and how very little is reported with acute patients. Sufficient good work has now been carried out on psychomotor functioning for it to be firmly established that the mentally ill perform less efficiently on such tasks, than do the mentally healthy. If this fact is now established, then it seems appropriate that psychomotor investigations should match the current trend of psychiatric practice, which is increasingly being concerned with an active therapeutic régime for the short-stay patient rather than simply providing custody for the long-term patient.

In addition to the broad separation of patients and normal subjects on psychomotor tasks, it has been more recently shown by Weaver (1961) that the more severely ill perform worse than do the less severely ill. Yet it is remarkably hard to find reference to *changes* in mental state being related to changes in psychomotor performance. It was with such a purpose in mind that this study was devised. One was faced with the clinical problem of trying to assess changes in response to therapy in an objective way. Such a procedure needed to be simple enough for very disturbed patients to be able to deal with it, yet sensitive enough to pick up relatively small changes in mental state. It

needed also to be brief to be practical. With these criteria in mind a battery of psychomotor tasks was devised.

APPARATUS AND METHOD

The battery that was used included six short tasks, taking some 15–20 min. to administer. There were four writing tasks, followed by a peg-board and a simple reaction-time task. The writing tasks were:

(*a*) The subject was asked to write his name. The subject's performance was not assessed in any way. The purpose of this introduction was simply to reduce possible anxiety at the test situation by the presentation of something with which he could feel at ease.

(*b*) Subject then wrote 'United States of America'—being a piece of unfamiliar writing but still non-stressful.

(*c*) A sequence of written OXOX in capitals was timed over 15 sec., the subject being instructed to write as quickly as possible for that time. This task demanded constant changes from one cipher to the other.

(*d*) A series of continuous loops concluded the writing tasks. These gave a measure of the rhythmic continuous movement of the subject's handwriting. This task was not timed.

Measures were obtained from the subject's writing as follows:

(i) The total length of writing in centimetres for 'United States of America'. Length was used rather than any other measure in the light of the findings reported by Legge, Steinberg & Summerfield (1962).

(ii) The total number of OXOX written in the set period.

(iii) The number of loops contained within a distance of 2 in.

The peg-board was an uncomplicated one, consisting of 63 pegs set on one side of the board,

to be moved across to the other (see Hetherington, 1956). The pegs were moved first with the right hand, then the left and finally using both hands together. A rate of work score was derived in terms of the mean number of pegs moved per second.

The R.T. situation was of the 'classical' type, involving response to a light (reinforced with a background sound) at randomized intervals of 1, 2, 4, 8 and 16 sec. The intervals were automatically regulated. Response was by means of a spring-loaded button and measurement was in 0·01 sec. Twenty responses were made after a trial run had adequately familiarized the subject with the test situation.

Among the patients there were 22 men and 22 women. Ages ranged from 16 to 72 (mean 45·2 years): 17 were under 40.

There were 17 male and 17 female normals, whose ages ranged from 17 to 62 (mean 31·6): 22 were under 40.

Subjects tested consisted of 44 patients and 34 normals. The patient group consisted as nearly as possible of the consecutive admissions to an acute ward. All patients were required to perform on the battery on three separate occasions. The first was within a few days of admission to hospital; wherever possible the day of admission was avoided to minimise the effect of admission itself on results. Also wherever possible testing was prior to any treatment. For this reason, patients receiving E.C.T. urgently were excluded. The second occasion of testing was after approximately 3 weeks. This interval was selected on two assumptions:

(i) most patients stay for around 6 weeks so this would represent a 'half-life' and leave time for further testing;

(ii) most patients show their most marked improvement within the first 3 weeks. The third occasion was again after approximately 3 weeks.

In some cases this was close to the date of discharge; with others there was little or no change by this time, but they were tested none the less for the sake of a uniform experimental situation.

In order to gain some sort of comparison with normal performance, a group of hospital employees co-operated in the same way. It happened, conveniently enough, that 12 of these were student nurses, who at the first occasion of testing, were within 2 days of starting training in this hospital; their circumstances therefore had a lot in common with the patients, but without the mental illness.

Patients and normals were grouped for the purpose of aggregating data in accordance with their age (under 40 and 40+), sex, and intelligence (Progressive Matrices). No attempt was made to group the patients in terms of diagnostic categories, since the evidence over the years suggest that such differentiation is both difficult and confusing. Patients were included irrespective of diagnosis in the hope of providing some evidence for the belief of Brooks & Weaver (1962) that it is 'most probable that this psychomotor deficit applies to mental patients as a class'. In fact this group contained neurotics and psychotics, functional and organic, in a distribution fairly characteristic of the ward in question.

While it was clearly not possible to control all the variables one could wish to in such a context, none the less a good level of procedural uniformity was possible. All subjects were tested by one person in one room, which was quiet and undisturbed.

RESULTS

(a) Handwriting

Only a passing reference will be made to this since it is not possible to speak meaningfully of group trends. One purpose of including these items was to assess the side-effects of certain drugs used during therapy. Such results will therefore be dealt with elsewhere. In addition, however, due to the range of psychiatric diagnoses included, the trends from one patient to the next were not consistent.

Three generalized observations can be made:

(i) The group of normal subjects showed very consistent results on all the measures of handwriting used.

(ii) The size of writing increased as patients who had been depressed improved in mood; conversely patients who were in states of excitement on admission produced smaller writing as they improved clinically.

(iii) The output of material on the timed writing task tended to increase as depressed patients improved.

(b) Peg-board

There was a clear discrimination between patients and normals, when age and sex were taken into account (see Table 1). As with most such tests, men performed faster than women, and the younger subjects were faster than the older.

There is a slight improvement through the three occasions among the normal groups, presumably due to practice. The trend for patients as a group is little better (Table 2) because some were not improving clinically and most were receiving drugs; but the trend for patients independently judged to be improving clinically showed a much more marked degree of test improvement. The level for these still does not match that of the normals since although they had greatly improved, it would be incorrect to describe them as recovered.

(c) Simple reaction time

For several reasons these results were subjected to more detailed treatment than the rest of the battery. In particular, the number of variables capable of investigation was greater than among the preceding tests. Each subject by the end of the three test sessions had given 60 responses, 12 to each preparatory interval.

First, the total distribution of scores was plotted and the curve was found to be characteristically skewed—the result was, in fact, remarkably close to that shown by King (1954). In order to handle the data statistically, all raw scores were therefore transformed by the expression $S = K/x$, where x was the raw score, and K a constant of 200. When scores were plotted, they were then found to be sufficiently close to a normal distribution to justify parametric statistical techniques. This serves to reinforce credence in the estimates of statistical significance yielded in the F ratios. It also made it possible to include *all* responses rather than exclude those beyond an arbitrary point, as has often

been the practice. By means of the transformation, the normal mean level of performance is emphasized while the abnormally long R.T.s do not artificially distort mean scores.

A t test was carried out on the distribution of patients' and normals' responses, which showed them to be significantly different ($t = 26 \cdot 1$; $P < 0 \cdot 001$). Analyses of variance were then carried out on the patient and normal records separately. An individual analysis of each patient's results was also made. The features included in the analyses of variance were:

(i) age (under 40 and 40+);
(ii) sex;
(iii) intelligence (Progressive Matrices);
(iv) preparatory intervals (1, 2, 4, 8, 16 sec.);
(v) within-test groups (20 responses subdivided into 4 groups);
(vi) progress (three occasions of testing).

Table 1. *Scores in pegs per second achieved on the peg-board over three occasions of testing by normal and patient groups*

	Normals Occasions			Patients Occasions		
	1	2	3	1	2	3
Male						
Over 40	0·91	0·89	0·89	0·63	0·68	0·67
Under 40	0·84	0·88	0·89	0·67	0·67	0·73
Female						
Over 40	0·79	0·82	0·81	0·60	0·63	0·70
Under 40	0·83	0·87	0·87	0·64	0·69	0·69

Table 2. *Scores in pegs per second on the peg-board for normals and patients, together with the improving sub-group*

	Occasions		
	1	2	3
Normals	0·83	0·87	0·87
Patients	0·63	0·66	0·65
Markedly improved patients (14)	0·61	0·67	0·69

The purpose of including the within-test grouping was to determine whether there was any significant learning or fatigue effect. There was none, save in one individual analysis, so this element is dropped from the reported results. Its absence indicates that each test situation may be accepted as a homogeneous sample of the subject's responses. The results of the two group analyses are presented in Table 3. Only the significant interactions are included.

In assessing the significance of these data, it must be recognized that the patients group performed at a quite different level from the normal group. Hence the sort of fluctuations which occur in normal records as a result of minor test variables (e.g. time of day, as indicated by Knight (1962)), are of less importance than is the contribution of factors related to mental state. The relative performances of patients and normals are shown in Fig. 1.
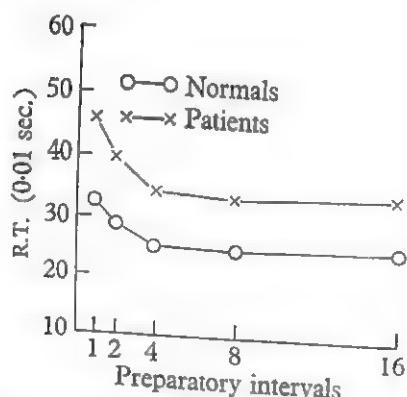
Fig. 1. The performance of patients and normals for each preparatory interval on the first occasion of testing.

The following conclusions have been drawn from the results presented above.

(1) The normal group performed significantly better than did the patients.

(2) There was a clear sex difference—men consistently faster than women.

(3) Responses to short P.I.s (1 and 2 sec.) were slower than to the longer P.I.s (save for a small group in whom the reverse trend was seen).

(4) Age is fairly certainly a significant factor though the presence of interactions makes this less clear in this study. Others have pointed to the same effect (e.g. Bellis, 1933; King, 1954; Hall & Stride, 1954).

(5) There is no clear evidence that intelligence was important. The evidence of Tizard & Venables (1956) would suggest that the effect is at most negligible.

(6) The lack of a learning or fatigue effect within test sessions indicates not only that preliminary trials had been sufficient to produce a stable level of response, but also that the difference between patients and normals cannot be accounted for by differences in effort tolerance.

(7) Two first-order interactions which are more important among the patients than the normals ($A \times I, A \times S$) are probably due to the wider scatter of age and intelligence among the patients.

(8) The effect of progress is much greater among the patients than among the normals, but is contributed to only by *some* of the patient group. The significance of this will be considered below.

(9) 42 % of the variance is accounted for by the tabulated factors and their interactions in the patients' analysis as compared with 30 % in the normals' analysis (Table 3). This suggests that extraneous factors are of greater importance in influencing the normal records than those of the patients; this is as one would expect since the normals are bordering on the best possible level. This also underlines the need in all such testing for careful control of extraneous circumstances.

CLINICAL USEFULNESS OF RESULTS

Results obtained by some of the patients on the battery during the three test sessions showed dramatic improvement. Others showed no change while a few declined in efficiency. The acid test of the procedure was therefore to ascertain whether these statistically significant changes were the result of change in mental state as hypothesized. If so,

Table 3. *Analyses of variance on patient and normal groups*

Normals

Source	Sx^2	D.F.	Variance estimate	Variance ratio	Significance
Age (A)	16	1	16	9·58	$P < 0·01$
Sex (S)	237	1	237	141·91	$P < 0·001$
Waiting intervals (W)	615	4	154	92·2	$P < 0·001$
Intelligence (I)	87	3	29	17·36	$P < 0·001$
Progress (P)	63	2	32	19·16	$P < 0·001$
A × S	9	1	9	5·39	$P < 0·05$
A × I	15	3	5	2·99	$P < 0·05$
A × P	15	2	8	4·79	$P < 0·01$
S × I	128	3	43	27·74	$P < 0·001$
S × P	20	2	10	5·99	$P < 0·01$
W × I	61	12	5	2·99	$P < 0·001$
A × S × W	19	4	5	2·99	$P < 0·05$
A × S × I	21	3	7	4·19	$P < 0·01$
A × S × P	21	2	11	6·59	$P < 0·01$
A × I × P	55	6	9	5·39	$P < 0·001$
Residual	3304	1983	1·67		
Total	4710	2040			

Patients

Source	Sx^2	D.F.	Variance estimate	Variance ratio	Significance
A	46	1	46	15·3	$P < 0·001$
S	1459	1	1459	48·6	$P < 0·001$
W	1073	4	268·25	89	$P < 0·001$
I	933	3	311	104	$P < 0·001$
P	487	2	243·5	81	$P < 0·001$
A × S	184	1	184	61	$P < 0·001$
A × I	940	3	313·3	104	$P < 0·001$
A × P	61	2	30·5	10	$P < 0·001$
S × P	82	2	41	14	$P < 0·001$
I × P	132	6	22	7	$P < 0·001$
S × I × P	197	6	32·8	11	$P < 0·001$
Residual	7702	2608			
Total	13296	2639	2·95		

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then it dispels the possibility that changes simply represented an adjustment to hospital admission.

To determine how far results on R.T. testing related to clinically observed status, a rating was requested from the psychiatrist responsible for each patient, *before* he knew the test results, as to whether there was 'No improvement', 'Some improvement' or 'Marked improvement' over the 6-week period. It happened that all categories were well represented. The comparable evaluation of R.T. performance was carried out purely mathematically *after* the psychiatrist had given his opinion. The individual analyses of variance were worked out and attention paid to the level of significance of P (progress). If this was highly significant $(P < 0.001)$, 'marked improvement' was scored; if $P > 0.001 < 0.05$, then 'some improvement'

Table 4. *A comparison of assessments by the psychiatrist and by changes in R.T. performance*

R.T. Assessment	Doctor's Assessment			
	No improvement	Some I.	Marked I.	Total
No improvement	12	3	1	16
Some improvement	1	1	5	7
Marked improvement	1	6	14	21
Total	14	10	20	44

was scored, while a non-significant result, or one showing significant decline, was scored as 'no improvement'. Thus the criteria for each subject were obtained solely from the internal evidence of that subject's performance without regard to population parameters. The relationship between the doctor's opinion and R.T. performance is shown in Table 4.

The extremes show clear agreement: the criterion of 'some improvement' shows less agreement. Three reasons are put forward to account for this:

(i) the psychiatrists were less easily able to rate this category than the others;

(ii) in some cases the R.T. result is probably *more* sensitive to change than clinical judgement (cf. Hall & Stride, 1954; Lundholm, 1922);

(iii) in some cases this part of the battery may not have been a particularly appropriate measure, or the information selected was inappropriate, so disagreement arises.

The above data show that results on the R.T. test correlated highly significantly with the psychiatrist's assessment ($P < 0.001$ using Good's Exact Test (1950)). It must be stressed that this level of agreement was achieved using only one part of the battery; King (1954) speaks of isolating three factors with only low positive correlations, and the use of three tests would presumably yield more information than one. Correlations have been worked out between the peg-board and R.T. tasks in this study which show close agreement with King's findings. Between Lift R.T. and Assembly, King quotes a correlation of 0.35 for patients; the comparable figure for this patient group was 0.37. Seashore (1951) gives a figure of 0.15 for normals, which again compares closely with 0.13 in this study. In view of these low correlations no attempt has been made to combine scores at present; it seems likely that the peg-board task and the R.T. task are providing rather different information. The impression received is that the R.T. task is highly sensitive to changes in mental state and influenced only a little by drug side-effects, whereas the peg-board task shows more clearly the slowing influence of drugs on performance so frequently reported in studies of psychomotor function. This relationship is not the subject of the present paper, and will be pursued in more detail elsewhere.

SUMMARY

A battery of psychomotor tests was administered to a group of acute psychiatric patients on admission to hospital and at intervals

during their stay. A group of normal subjects was tested in the same way. The purpose of testing was to attempt an objective measure of changes taking place particularly in mental state. Independent uncontaminated clinical ratings were therefore obtained from the psychiatrists responsible for each patient.

It was found that quite considerable changes in the size of handwriting were associated with changes in mood, constriction being related to depressive states and expansiveness related to states of excitement. Rate of work on a continuous dexterity task (peg-board) increased with improved mental state, but findings were in part obscured by the contrary effects of drugs. The speed of initiating a response (simple R.T.) was found to relate significantly to mental state and to be less affected by the contrary effects of drugs.

On the basis of these findings it is suggested that a short battery of psychomotor tests can provide useful information concerning the mental state of a wide range of psychiatric disorders, and that periodic retesting is sufficiently reliable to justify conclusions concerning changes in condition and the effects of a given therapeutic regime.

REFERENCES

BELLIS, C. J. (1933). Reaction time and chronological age. *Proc. Soc. Exp. Biol., N.Y.* **30**, 801.

BROOKS, G. W. & WEAVER, L. A. (1962). Psychomotility, drugs and schizophrenic rehabilitation. Final Report U.S. Public Health Service Grant MY-1752.

GOOD, J. J. (1950). *Probability and the Weighing of Evidence.* Griffin.

HALL, K. R. L. & STRIDE, E. (1954). Some factors affecting reaction times to auditory stimuli in mental patients. *J. Ment. Sci.* **100**, 462.

HETHERINGTON, R. (1956). The effects of E.C.T. on the efficiency and retentivity of depressed patients. *Brit. J. Med. Psychol.* **29**, 258.

KING H. E., (1954). *Psychomotor Aspects of Mental Disease.* Cambridge: Harvard University Press.

KNIGHT, D. (1962). Test score instability as a source of error in drug research. Paper read to the B.P.S. London Conference.

LEGGE, D., STEINBERG, H. & SUMMERFIELD, A. (1962). Measures of handwriting as indices of drug effects. Paper read at the B.P.S. Annual Conference, Bristol.

LUNDHOLM, H. (1922). Reaction-time as an indicator of emotional disturbances in manic-depressive psychoses. *J. Abnorm. (soc.) Psychol.* **17**, 292.

SEASHORE, R. G. (1951). Work and Motor Performance. In Stevens' *Handbook of Experimental Psychology.* New York: Wiley.

TIZARD, J. & VENABLES, P. H. (1956). Reaction time responses by schizophrenics, mental defectives and normal adults. *Amer. J. Psychiat.* **112**, 803.

WEAVER, L. A. (1961). Psychomotor performance of clinically differentiated chronic schizophrenics. *Percept. Mot. Skills*, **12**, 27.

Reviews

The Evolution of Psychiatry in Scotland. By Sir David Kennedy Henderson, M.D., D.Sc., LL.D., F.R.C.P. (Pp. 300. 32s. 6d. net.) Edinburgh and London: E. and S. Livingstone, Ltd.

As Sir James Learmonth suggests in an appreciative Foreword, this book will attract many readers beyond those who are directly concerned with some form of psychiatric work. The historical chapters provide convincing evidence that the modern developments of humanitarian and scientific psychiatry have not been so sudden or recent as is sometimes assumed, but are directly related to, and based upon, the pioneer work of earlier medical and social reformers from the end of the 18th century, who contended successfully with a public ignorance and indifference almost incredible today. An honourable and durable part of this work was done in and for Scotland, and Sir David Henderson has done a valuable service by providing in such readily accessible form sketches of the lives and achievements of some of the men and women concerned, including details of the foundation and development of each of the seven Scottish 'Royal Asylums'.

The chapter on the beginnings of psychiatric research shows that some of 'the old psychiatrists', as they are sometimes rather disparagingly called, were as able and earnest as their successors in their efforts to understand and elucidate the problems of mental disorder. In spite of their limitations—in knowledge, equipment, facilities and finance—they initiated much real progress in research, in the best sense of that sometimes rather elastic term.

The more personal chapters of the book are no less interesting. Parts of Sir David's early psychiatric training and experience were in the United States and Germany, and his reminiscences of his work there, and of such well-known teachers as Adolf Meyer, Kraepelin and others, are vividly related. The record of his work in British psychiatry, especially of course in Glasgow and Edinburgh, has many details and comments which will be full of interest to the very large number of physicians and others who have had

some connexion with Gartnavel or Morningside at any time during the last 50 years, and references to some of the eminent psychiatrists with whom Sir David has been associated will revive memories for seniors, and remind juniors that they have entered into a goodly heritage.

Later chapters describe some of the changes Sir David has seen and shared in during his long career, in psychiatric ideas and outlook, in methods of treatment and in hospital organization, changes also in the symptomatology and relative frequency of various forms of mental disorder. In the pleasantly informal manner which characterizes the whole book, he discusses the present position and future prospects of psychiatry and its relations with general medicine, medical education, hospitals, legislation, social reforms, 'community care' and other matters much in debate at the present time. The modern extension of psychiatric ideas and interest into various departments and aspects of social life doubtless has its value and importance, but psychiatry is no more exempt than any other science or art or activity from the inevitable dangers of over-popularity—dilution by cheap substitutes, undue dogmatism, unqualified exponents, 'take-over bids', dissipation of energy, and diversion or lowering of aims and ideals. On some points Sir David's opinions are very definite but always fully reasoned, and they will be welcomed with the respect due to the long and varied experience and balanced outlook on which they rest.

DAVID YELLOWLEES

Criminal Responsibility and Mental Illness. By F. A. Whitlock. (Pp. 156. 40s.) London: Butterworths. 1963.

The author is a Consultant Psychiatrist at the General Hospital in Newcastle-upon-Tyne and an Associate Physician in the University Department of Psychological Medicine in the same city. Since the book went to press he has been appointed to the chair of psychiatry at the University of Queensland in Brisbane, Australia.

In the Preface he writes that he was moved to prepare the book because of newspaper reports of

two murder trials which persuaded him that the legal mind did not correctly appreciate the approach of modern psychiatry to the problem of mental disorders. This observation, and other internal evidence, suggests that the author has acquired his knowledge of medico–legal matters more from his thinking and reading than from much actual embroilment in the cut-and-thrust of the court-room. This is no bad thing: many psychiatrists, licking the festering wounds they have suffered in one-sided combat with judge and counsel, are too personally involved to regard the trial scene with temperate detachment and they retire defeated from their efforts to translate psychiatric concepts into the private language and logic of the jurist.

In his Introduction the author mentions his pessimism over the prospects for a good understanding between law and medicine but it is his aim to examine the basic views in the hope of bridging some of the differences. He believes these are in part due to the conflicting claims of individual and of society and that the psychiatrist's concern for the individual sometimes militates against the welfare of society. But too much can be made of this antithesis: quite often the psychiatrist's recommendation on an offender would protect society better and longer than the determinate, retributive sentence which may be all that the law allows itself, and many psychiatrists can recall violent men who ought to be detained indefinitely in a psychiatric establishment but because the psychiatric evidence is rejected they are released to the danger of the public after a short period of punitive imprisonment.

By and large, psychiatrists are responsible professional people who have made a special study of their subject and they ought to be given credit for their knowledge and experience, but the judiciary is jealous of its responsibilities and very sensitive to any encroachment. Here seems to lie the nub of the problem of resolving the differences: both law and medicine are dealing with the same material but from quite different points of view, with different intentions, different concepts, and with entirely different backgrounds of training. The image of psychiatry, in the eyes of the law and of the public, has not been beautified by the egregious displays of medical disunity that have disfigured our testimony in the witness box, but even here the setting of the trial is partly to blame:

the whole arrangement of examination-in-chief and cross-examination places a premium on dogmatism: the medical witness is insensibly persuaded to give definite answers to questions that cannot in truth be thus answered. If the psychiatrist is bewildered by the subtle and hypothetical legal reasoning the imagination boggles at the predicament of the juryman. We share and feel the despair of Dr Whitlock when he writes of a counsel who argued that a case of arteriosclerotic dementia was suffering from a disease of the brain and not of the mind. And yet there is some ground for believing that, apart from occasional astonishing and shameful examples to the contrary, the courts are being drawn, roaring a little, into the 20th century. Psychiatrists, who train themselves to treat psychosis by understanding rather than argument, can enlist their expertise to assist the modernization of men of law and it behoves us to aim at tolerance and understanding, to restrict our opinions to medical aspects, to ration ourselves in the proffering of advice on disposal and to be unashamed in admitting there are many aspects of the mind we cannot explain.

Starting with an historical account of the legal attitudes towards crimes committed by the insane, the author proceeds to discuss the M'Naghten Rules, and it is sad to see in the year 1963 it is still necessary to give 34 pages to these out-moded matters. He agrees with the majority view of the Royal Commission on Capital Punishment that the M'Naghten Rules should be set aside and that the jury should determine whether at the time of the act the accused was suffering from disease of the mind or mental deficiency, to such a degree that he ought not to be held responsible. But he pointed out how the Homicide Act, 1957, has already partly supplanted the M'Naghten Rules, because some offenders who before the Act would have been found to be guilty but insane are now found guilty of manslaughter. He stresses the risks to society that may follow this change. He quotes the Royal Commission who show that of 1070 persons suspected of murder, 737 were shown to be suffering from mental illness assuming (not an entirely valid assumption) that all those who committed suicide were mentally ill: this gave an incidence of mental disorder in suspected murderers of nearly 70 %. But the incidence of mental abnormality amongst the ordinary prison population is assessed by Dr Whitlock at about 12 % of the prison population

so he concludes that although the basis for such statistics is not completely reliable it does not seem that the overall incidence of mental abnormality in prison populations differs very much from that in the general community. He concludes that it is difficult to support the view that all crime is based on mental disorder and he quotes Norwood East with approval to the effect that if crime is a disease it is necessary to explain the high incidence of this form of mental disease amongst young men. The author notes that the number of those persons found guilty but insane before the passing of the Homicide Act, 1957, is just about equal to the combined totals of those persons who were found guilty but insane, and guilty of Section 2 manslaughter since the Act came into force: this means that a number of persons who would have been detained indefinitely in hospital are now liable to obtain their release after a fixed and limited period of imprisonment.

Other chapters deal with the mental conditions of responsibility and with brief descriptions of the various psychiatric syndromes: particular attention is devoted to the effects of disordered consciousness, disturbance of emotional reaction, delusional beliefs and disorders of intellectual capacity. In dealing with diminished responsibility, he is on well-tilled ground and he discusses the medical evidence where this plea has been put forward, especially in the case of psychopaths. The chapter on drunkenness, automatism and fitness to plead is up-to-date and is supported by pertinent references to recent important hearings.

In his final chapter Dr Whitlock draws together the conclusions that emerge from his study of the problems. Throughout the book, as is to be expected, the emphasis is on the special crime of murder and all will agree that much of the medico–legal controversy which has developed in the past would no longer occur if capital punishment were abolished.

The book contains indices of the legal cases cited, of names, and of subjects. The author has leaned heavily on Glanville Williams's *The Criminal Law*, on *The Report of the Royal Commission on Capital Punishment* and has obviously been stimulated, as have most psychiatrists, by the writings of Lady Wootton. The book is attractively produced but the price is somewhat high. Psychiatrists will read it with interest and benefit: it will be valuable to legal men too, and if it fails to effect a rapprochement between the two sides the fault will lie not in the author's clarity of thinking and writing but in the complexity and profundity of the subject.　　H. GILLIES

Psychogenic Psychoses. By PAUL M. FAERGEMAN. (Pp. x+268. 42s.) London: Butterworth and Co. (Publishers) Ltd. 1963.

The purpose of this book is to examine the nosological concept of the psychogenic psychoses which was introduced by Professor Wimmer in 1916. According to this Danish psychiatrist there is a group of psychotic reactions which are characterized by being initiated by psychic trauma and which have a good prognosis without personality deterioration. These conditions usually arise in individuals with a psychopathic predisposition. They are to be distinguished from the schizophrenias and manic depressive psychoses. In this present work Dr Faergeman has followed the fate of 170 patients who were diagnosed by Professor Wimmer as suffering from psychogenic psychoses between the years 1924–26. The investigation was undertaken 16 years later. The author follows Schneider's classification of psychogenic disorders and places the cases in the categories—emotional syndromes which include patients suffering from depressive reaction; disturbance of consciousness and paranoid syndromes.

When the mental status of the patients was examined at the time of the follow up the original diagnosis based upon the criteria outlined above was confirmed in about half the cases. In one-third a diagnosis of non-psychogenic psychoses was arrived at and in one-sixth no diagnosis could be made. Cases which fell into the paranoid group had most often to be revised with respect to the diagnosis. The condition most often erroneously diagnosed as psychogenic psychoses was schizophrenia. This study suffers as most retrospective investigations do from a dependence upon the clinical data recorded at the time of the original consultations. In spite of this, however, the British reader will be impressed with a clear picture of mental states which are described and which he may regard as frequently indicating the presence of a schizophrenic reaction. It would seem that Wimmer in common with many Continental psychiatrists did not regard hallucinatory phenomena or delusional ideation as predominantly schizophrenic manifestation.

This is a valuable book because it will make the reader ponder upon problems of clinical categorization and significance of individual symptoms for the diagnosis and prognosis of schizophrenic reactions. British psychiatrists will be inclined to regard psychogenic psychoses as atypical schizophrenias or as atypical manic depressive states, depending upon their own personal preferences. The author remarks that Wimmer disliked making a diagnosis of schizophrenia no doubt because he considered it a condition which always had a bad prognosis.

According to Dr Faergeman's criteria psychogenic psychoses is not a common condition, only amounting to 2 % of all hospital admissions. It is doubtful if the introduction of this concept into clinical practice would serve any useful purpose. Today many psychiatrists implicitly acknowledge the occurrence of psychogenic psychoses in so far as they regard the functional psychoses as having a psychic precipitation. The conception of a psychogenic psychosis implies the possibility that the schizophrenia and manic depressive psychoses do not have such an initiation. This is of course the approach of many British clinicians whose orientation is based upon the views of Schneider, Mayer-Gross and Jaspers. Dr Faergeman makes an attempt to present both points of view with the modest yet vital aim of making each aware of the others approach. This attempt will make the book valuable and indeed essential reading for anyone who has clinical contact with psychotic patients.

T. F.

Electrical and Drug Treatments in Psychiatry. By A. SPENCER PATERSON. (Pp. 248. 56s.) Elsevier Publishing Company. 1963.

This book on physical therapies is intended for the psychiatrist and for the general practitioner, and it was written because the author considered that these subjects had been cursorily treated in the textbooks. In fact, very much the same ground is covered in *Somatic Treatments in Psychiatry* by Kalinowsky and Hoch, and by *An Introduction to Physical Methods of Treatment in Psychiatry* by Sargant and Slater.

Dr Spencer Paterson has long been known as an ardent exponent of varied and sometimes adventurous techniques of electrical stimulation of the brain and to some of these techniques he has been more faithful than the generality of psychiatrists. In recent years he has had a neurophysiological laboratory at the West London Hospital where animal and human studies have been carried out. The first half of the book deals with E.C.T., electronarcosis, electrical anaesthesia, electrically induced abreaction and electrical sleep. The author's persuasive enthusiasm may lead the general practitioner into believing that all of these treatments are accepted parts of the psychiatrist's armamentarium. The history, literature and electrophysiology of these matters are clearly described and make stimulating reading for the psychiatrist who, however, will be less enchanted with the author's assessments of therapeutic value because these are often based on impressionistic criteria or on that *bête noire* of the psychiatrist which is the single case. This all-electric section of the book is specialized and is unlikely to have practical appeal to the family doctor.

The other half of the book gives a workmanlike, complete and uncontroversial account of the phenothiazines, anti-depressants and other drugs in use today. It will be instructive to psychiatrists and to general practitioners. The chapter on alcoholism must have been hurriedly written for it is disappointingly sketchy and misleading.

H. GILLIES

Experimental Psychology. Edited by A. SUMMERFIELD. *British Medical Bulletin.* (**20**, 1, 1–86. £1. 10s.) London: British Council. 1964.

Recent advances in experimental psychology which have received much of their impetus from British laboratories are reported here in fifteen short papers. The first seven are concerned with such ego functions as learning, memory, attention, perception, decision-making: 'aspects of how men acquire and use skills, knowledge and information'. Much of the discussion in this part is in terms of cybernetics, the science of communication and control, which has been developed mainly by engineers. These and other technical terms are briefly elucidated on their first appearance so that the reader has no difficulty in sharing these exciting developments. Indeed it is a pleasure to read such a carefully edited symposium. The remainder of the papers in this issue deal with some of the changes which affect

behaviour such as ageing, sleep, drugs, neuro-
logical intervention and sensory deprivation.

Apart from the paper on psychological aspects
of neurology there is little mention of experi-
mental work having a direct bearing on psychiatric
problems. Nevertheless, these new perspectives-
are of considerable interest to medical psycho-
logists. Some of the ideas and techniques out-
lined here have found fruitful application in
psychiatric research already. Many more will un-
doubtedly be found relevant in the future.

C. E. GATHERCOLE

Group Psychotherapy and Group Function.
Edited by MAX ROSENBAUM and MILTON M.
BERGER. (70s.) Basic Books Inc. 1963.

The editors, one a psychologist and the other
a psychiatrist, both practising in New York, have
included in this collection papers essential for
understanding the development of group psycho-
therapy, some of which were very hard to obtain.
The founder of the method, Joseph Pratt, is
represented by two papers, a 1917 one on 'The
Tuberculosis Class' and a late one of 1953 when
he wrote as a frank psychotherapist rather than
as physician. The long Introduction by the editors
will be of interest to readers unfamiliar with the
names of clinicians and group dynamicists who
developed the psychiatric applications of group
processes; regrettably it is little more than a
catalogue; critical evaluation is not attempted.

A two-volume work had been intended but
this plan was defeated by 'practical considera-
tions'; a second volume is promised which will
relate group psychotherapy with its associated
field of inquiry, group dynamics. In this book
group dynamics is meanly represented: Asch and
Sherif are each embodied in reviews of their work
written for *Scientific American*. The papers
selected for reprinting are mainly by clinicians.
Dr Moreno's paper is one which, as the editors
explain in a footnote, he pressed for rather than
another they had requested. His claim for it is
that 'it contains the first comprehensive table of
the basic categories of group psychotherapy, a
tabulation which has hardly been surpassed in
the course of years'.

The editors have not accepted the challenge
to provide a usable if tentative summary of
theory, nor have they aimed for a taxonomy of

group processes for the benefit of clinicians and
investigators who may be stimulated by this book
to a greater interest in groups. Actual observa-
tions are rarely reported; Paul Schilder's pioneer
paper, with case findings, is seldom equalled,
although more sophisticated concepts are now
available to study the phenomena he observed in
1939 as patients in a group gradually come to
perceive that their thoughts—which had served to
isolate them—are common to others. He grasped
the difference between group and individual
treatment, the patient in a group being able to
witness the actual manifestation of identical
impulses in others.

Unsubstantiated opinions flourish, sometimes
brilliantly expressed. Private letters from Jung
set out his well-known fears that suggestibility is
increased in groups, and increased suggestibility
leads to the individual's bondage; the danger of
group therapy lies in the possibility of a standstill
on a collective basis. A stranger in the book is
D. H. Lawrence, reviewing a work by Burrow:
'Even sex, today, is only part of the picture.
Men and women alike, when they are being
sexual, are only acting up.'

The reader will find enough to ensure that he
refers repeatedly to this book, even though he
has to search for the gold in the dross. Dorothy
Baruch has a 1945 study of the leadership
techniques she was found to use in conducting a
group made up of professional people on a
college course. She brought emotions into sharper
focus; she made collective meanings apparent;
she facilitated working through of collective
meanings. The most important aspects of her
leadership were considered the permissiveness,
acceptance and empathy she expressed.

Slavson's 1943 paper, deriving from his use of
activity groups to treat emotionally disturbed
children, cautions that a group approach is only
effective with those patients whose treatment
needs are specifically met by the group situation,
and can only be employed where there are
psychiatrically trained personnel and psychiatric
consultative services.

Corsini and Rosenberg examined 300 articles
on group psychotherapy. By a process of reduc-
tion they distil out three factors: an intellectual
one (universalization, intellectualization and
spectator therapy); an emotional one (acceptance,
altruism and transference); an actional factor
(reality testing, interaction and ventilation).

A. Wolf's lengthy paper, extremely readable and informative, sets out his own bias that 'we do not treat a group. We still analyse the individual in interaction with other individuals.' He finds support from this denial of the importance of group dynamics for his practice of combining group therapy with individual psychotherapy. (In fact, his group patients are prepared by an initial phase of individual treatment.) His bias, however, does not deter him from the use of 'alternate' meetings, from which the conductor is absent, when the therapeutic effects must derive from the group itself. Not surprisingly, he obtains and accepts the development of some sexual relationships between patients. In other ways also he is more directive than British group therapists usually are; they tend to recognize more the advantages of a 'closed' group and would not accept Wolf's technical approach that '...the group never disbands entirely'. British readers will note that Kraupl Taylor and Maxwell Jones are unrepresented, Foulkes only by a 1946 paper about work in a military centre. Bion does not himself appear, although the editors summarize his concepts, and his formulations form a basis for Stock and Thelen's paper on emotional dynamics. They see Bion's originality in his emphasis on two phenomena in groups: the group's mood, and individual members' reactions to the group situation. These writers stress more than many of the clinicians who are represented that, both in technique and concept, there are important differences between group and individual psychotherapy.

                                              H. J. WALTON

Psycho-Analysis and Faith. The Letters of Sigmund Freud and Oskar Pfister. Edited by HEINRICH MENG and ERNST L. FREUD. (Pp. 000. 00s.) London: Hogarth Press.

Various aspects of this book combine to make it a 'must' for anyone who is seriously concerned about the possibility of preserving religious faith while at the same time absorbing and assimilating the analytic truth about life as exposed by Freud. At the same time it provides an attractive, brief, and lively account of the development of psycho-analysis through the years, with all the vividness of personal correspondence. Perhaps the best feature is the way in which Freud emerges as a person, not only of genius but great humanity.

Oskar Pfister, a Protestant pastor of Zurich until his retirement in 1939, came across the work of Freud in 1908 and found in it a tool for which he had long sought, enabling him to give additional aid to those for whom his spiritual aid alone had been insufficient. A long and unbroken friendship followed until Freud's death, with occasional meetings, exchange of publications and many letters from which shine the honesty and integrity of both men, at times sharp conflict, but always great tolerance and mutual respect. Letters referring to Freud's book *The Future of an Illusion* and Pfister's courageous reply *Illusion of a Future* form the climax of the most controversial aspect of their correspondence, and the high level of scientific discussion survives the test, leaving difference of opinion but not of basic outlook. Pfister is in bed suffering from phlebitis when writing his critical letter and Freud acknowledges it expressing gratitude for the worthy and friendly way in which his *Illusion* was answered from within their own circle. But he is sorry for his friend and critic who is indisposed '...Your active way of life, your mountain-climbing should have assured you better circulation than that...' and in closing wishes Pfister 'a speedy recovery and resurrection'. That was in 1928 and Freud says '...What I shall think of these things in 10 years' time I do not know—I hope it will be nothing at all...'.

Throughout the arguments for and against religious faith one sees the strength and integrity with which Freud faces his friend with facts which are necessary for real progress in their thinking. He reminds Pfister when he seems to be paying too little attention to sexual theory, at the same time expressing envy of Pfister, whose patients Freud believes have a scope for sublimation into religion which is lacking in non-religious patients. 'It is natural that at this point in therapy our ways should part....Why was it that none of all the pious ever discovered psycho-analysis?... Why did it have to wait for a completely godless Jew?' Pfister replies '...you are not godless, for he who lives the truth lives in God, and he who strives for the freeing of love "dwelleth in God". ...If you raised to your consciousness and fully felt your place in the great design, which to me is as necessary as the synthesis of the notes is to a Beethoven symphony, I should say of you; A better Christian there never was....'

Freud showed genuine appreciation of Pfister's

progress in his pastoral and theological life as well as his development as a psychoanalyst. He was warm in his congratulations when Pfister attained his jubilee in the church, and when he received an honorary degree in theology. 'That you should be such a convinced analyst and at the same time a clerical gentleman is one of the contradictions that make life so interesting.'

While reading these letters one is sometimes following a specific phase of development of analytic theory, or the vicissitudes of a particular analytic society, or Freud's reactions to the death of a beloved member of his family or a valued colleague, descriptions of holidays or visits of friends to the house, how things are moving in England and elsewhere, and many other glimpses of Freud as a person.

Theologian and psychologist alike could derive help from this record of faithful friendship and devotion to psychoanalytic study, and any-one keen to know what Freud was like should not fail to read this volume of personal corres-pondence. SIMON LINDSAY

Contact with Jung. Essays on the Influence of his Work and Personality. Edited by MICHAEL FORDHAM. (42s.) London: Tavistock Publications. 1963.

After Jung's death the *Journal of Analytical Psychology* circulated the members of Jungian societies asking for (1) contributions on what has been the most significant stimulus that each had derived from Jung, or (2) articles on the origins and prospects of analytical psychology in the various parts of the world.

About a quarter of the 42 contributions deal with the latter question and show that Jung's influence abroad has been strongest in Britain. In the U.S.A. Jung's influence began only in the 1920's in New York and in the 1940's in California and these are the only two centres where Jungian Societies exist. Outstanding amongst the articles on the prospects of analytical psychology in various countries is the one by Ernst Bernhard about the psychology of the Italians which he regards as ruled by the Mediterranean Great Mother. It is helpful to everyone who has to treat patients of Italian origin.

The other contributions are equally divided between recollections of meetings with Jung and

papers on the salient aspect of Jung's teachings according to the light of each contributor. Amongst these, L. Stein's paper on 'Language and Archetypes' deserves special mention. It discusses the help a student of comparative philology could derive from Jung's findings.

All the articles are distinguished by the absence of any polemic against the other analytical schools and more than one expresses the hope that the time of misunderstandings and prejudices is past and a fertile discussion between the various analytical schools may be in sight.

KARL M. ABENHEIMER

Zur Methodologie der psychiatrischen Diagnostik und Forschung. By W. SCHUMACHER. (Pp. 116. sFr. 20.) Karger: Basle. 1963.

This book discusses the well-known problems of psychiatric research, that is the difficulty of diagnosis, the pitfalls in the description of psychiatric symptoms and the value of the experimental approach in psychiatry. Having dealt with all these difficulties and outlined the necessary safeguards, the author then discusses the unsatisfactory nature of much of the research in psychopharmacology. Although this book deals with topics with which most English-speaking psychiatrists are familiar, it is a valuable addition to the German literature on psychiatric research.

FRANK FISH

Psychological Basis of Medical Practice. Edited by HAROLD I. LIEF, VICTOR F. LIEF and NINA R. LIEF, Hoeber Medical Division, Harper Row, New York. (Pp. 572. $12.50.)

This volume gives a good general account of a psychosomatic approach to the practice of medicine. Avoidance, for the most part, of unnecessary technical jargon contributes to ease of reading and of understanding. Conceptual controversies are successfully evaded, helped unfortunately in some of the contributions by a somewhat too superficial handling. Despite a multiplicity of contributors (there are 52 distinguished authors), the book has been made cohesive by good planning.

The book is comprehensive in scope, ranging from such fundamental aspects as mind–body relationships and psychophysiology, through the many relevant specific disorders in men, women and children, to management treatment and rehabilitation. It is particularly pleasing to see contributions concerning pre-operative and post-operative surgical care, the psychological management of the cancer patient and his family and the psychological effects of serious illness and of surgical procedures. These are topics which too frequently receive little more than lip service. It is also pleasing to note a critical approach to research methodology by some of the contributors.

Without necessarily agreeing with the views expressed by all the contributors, it is fair to say that the editors have succeeded in their declared aim to provide a useful book on the psychological aspects of medicine, primarily for the medical student and the non-psychiatric physician rather than for the psychiatrist. It could, however, also be read with considerable benefit by some psychiatrists whose links with general medicine have tended to be tenuous.

DAVID M. KISSEN

Letter to Editor

17 October 1963

Dear Sir

I would be obliged if you would permit me to reply to Dr Jackson's accusations that I did your readers 'a real disservice' in my review of Gregory Bateson's edition of Perceval's *Narrative*. But may I first correct a factual error in Dr Jackson's letter? Bateson did not publish 'an old manuscript' as stated by Dr Jackson: he edited John Perceval's book entitled: *A Narrative of the Treatment Experienced by a Gentleman, during a State of Mental Derangement, etc.* first published in two volumes 1838 (pp. 278) and 1840 (pp. xxviii + 430).

Nevertheless, this new edition of a rare book is well worth republishing as it is of considerable historical interest. Surely the editor of an autobiographical account of a psychotic illness occurring in 1830 should be expected to place it fairly and squarely within its historical, social and biographical context? Dr Bateson failed to do so, and hence my criticism. Two eminent historians of psychiatry, Dr Richard Hunter and Dr Ida Macalpine, have made similar though stronger criticisms.* 'His [Bateson's] treatment of Perceval's life is sketchy not to say cavalier,' they write, 'his commentary devoted to

modern and perhaps ephemeral psychopathological theories he sees reflected in the *Narrative*, his notes on the text almost nonexistent. The reader will look in vain for annotations on the famous Fox family of Brislington House near Bristol...or of the Newingtons of Ticehurst, Sussex where he was moved in 1832. It is a pity that Dr. Bateson has not attempted to redress the balance or provide the necessary background to enable the modern reader to exploit the psychiatric treasures of the *Narrative* to the full.' Bateson's edition can only be fully appreciated if it is read in association with Hunter & Macalpine's review which is the result of much original research.

But Dr Jackson's main criticism is my failure to interpret Perceval's illness in terms of communication theory. It is true that his psychosis serves to illustrate the double bind theory: it can also be interpreted in terms of other theories. However, I do believe that it would be impertinent of a reviewer to impose any theoretical interpretation of a psychotic illness on the readers of your specialized journal.

Yours sincerely,

Kenneth Dewhurst

Littlemore Hospital,
Littlemore,
Oxford

* Hunter, R. & Macalpine, I. (1962). John Perceval 1803–76, Patient and Reformer. *Med. Hist.* **6**, 391–5.

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AMSTERDAM—NEW YORK—LONDON—MILAN—TOKYO
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The significance of the one-way vision screen in analytic group psychotherapy

By JOHN D. SUTHERLAND* AND HARWANT S. GILL†

I

The use of the one-way vision screen in analytic group psychotherapy stems from the need to provide students and research workers with a first-hand experience of the phenomena occurring in psychotherapeutic relationships. An alternative practice to the use of the screen is the introduction into the room with the therapist of one or two trainees assuming the roles of (i) a co-therapist, (ii) a participant observer, or (iii) a non-participant observer. A co-therapist is involved in the therapy as actively as the group therapist. The division of the patient's feeling between the two therapists, however, proves to be a negative feature in the treatment situation, since the crucial point for psychotherapeutic change seems to be the bringing together of the patient's ambivalent feeling towards the same therapist. The discrepancy in skill, moreover, between a trainee and an experienced therapist introduces further complications. A participant observer in group therapy intervenes only occasionally, remaining silent or taking notes most of the time. A non-participant observer takes no part at all in the group's discussions and, unlike the participant observer, sits clearly separated from the group. In comparison with having observers present in the therapy room, observation through a screen has distinct advantages to offer: (i) more trainees can be accommodated, (ii) new observers can easily be introduced during the course of several years' therapy without

creating recurrent disturbance in the group, and (iii) it is possible for senior therapists to observe each other's technique in occasional sessions.

A therapist making use of the one-way screen for training purposes is confronted with two kinds of questions: (*a*) those pertaining to the ethics of the situation, and (*b*) those concerning the possibly deleterious effects on the treatment. The ethical questions concern the therapist's professional responsibility not to betray the patient's confidence, and have been met in various ways. The patients are given a free choice in the situation: they are told about the screen and the demands of training; and, in the case of an objection, an alternative group is made available to the patient. The responsibility for proper selection of the observers rests with the therapist; he exercises control over admission to the observation room and only *bona fide* professional workers are permitted to observe. With these safeguards it is hard to believe that the use of the screen shows less respect for the patient than does the situation in out-patient clinics where an interview may be conducted in front of medical students and allied staff.

While the objections arising from ethical considerations can be met, no easy answers have been possible to questions about the effect of the screen upon therapy or about its dynamic significance for the patients. Prejudgements are common on this matter. The present study was conceived in an attempt to clarify some of the issues involved and to suggest hypotheses based on a careful examination of the tape records available for a therapy group.

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The questions that the study hoped to consider were as follows:*

General effects

(1) Does the screen exert an overall effect on the group situation?

(2) If so, what is the nature of the effect? Thus:

(*a*) Does the screen act as a general distraction such as a constant unpleasant noise might?

(*b*) Does it have a general inhibiting effect, e.g. by making the members more self-conscious or by inhibiting the expression of more personal and intimate feelings?

(*c*) Does it become a dynamically significant feature of the situation, the effect of which is more complex than either distraction or social inhibition tend to suggest? For instance, would those disturbed by the screen be using it at least in part as a resistance?

(3) Does the screen have a selective psychodynamic effect in evoking certain clusters of phantasies in the group as a particular Rorschach card might, e.g. paranoid fears?

(4) Are the effects manifested in an obvious form so that concern about the screen is a conscious one, or are they indicated less directly, e.g. in dreams?

Differential effects

(5) Does the screen affect only certain patients?

(6) If so, how do the effects vary amongst those affected?

(*a*) Do some patients show more intense reaction to the screen than others?

(*b*) Do patients vary in their mode of response, e.g. are some affected mainly consciously while others resort to more indirect forms of expression?

(7) Are individuals with certain kinds of difficulty or make-up more prone than others to be affected?

* Questions concerning the effect of the screen on the therapist, though highly relevant, could not be considered in this study due to insufficient data.

Effects of group process

(8) Do the effects vary at different times?

(9) If so, are they associated with any external characteristics of the group situation, e.g. times of holiday breaks?

(10) Does the prevalence of certain feelings in the group lead more readily to the screen becoming a topic of concern, e.g. feelings of dependence or depression?

(11) When one member refers to the screen, what purpose does it serve at the time?

(12) On each reference, does the screen become a group theme? If sometimes it does and at others it does not, how can these different developments be explained?

It will be clear that many of the above questions are basic to the whole process of group psychotherapy, and answers to them will have an application beyond the screen *per se*. Such is the case with Question (12), for example, which is concerned with differentiating between the times when an issue becomes and when it does not become a group theme. Questions of wider significance for the understanding of group processes have accordingly been given more attention.

While several of the hypotheses suggested might be applicable to group processes in general, some of them might not hold true for all kinds of group structure or where the technique of therapy differed widely from the one used. The present study is exploratory in character and is based on the limited data provided by a single therapeutic group taken by the senior author. The group is described below, along with a brief account of the psychotherapeutic approach commonly used at the Tavistock Clinic.

The group

The group consisted of four men and four women, ranging in age between 30 and 40, all of superior intelligence and of similar educational background. The difficulties for which they had sought help included the common psychoneurotic symptoms and character problems, e.g. inadequacies in social relationships and in work, claustrophobia and exhibitionistic anxiety, obses-

sional behaviour, and psychosexual difficulties. In all cases, the symptoms were of many years duration; three patients had had in-patient and two of them out-patient psychiatric treatment.

One of the women dropped out of the group after 4 months, so that by the time of the second screen reference in Session 21 there were only four men and three women patients in the group.

The group room was a small one with a screen, 6 ft. long by 3 ft. high, on one of the longer walls. Two microphones were suspended from the ceiling about 5–6 ft. from the floor over the centre of the group circle.

Sessions of 1½ hr. were held weekly.

The therapeutic method

The therapeutic approach used in this group was the one developed at the Tavistock Clinic and based on the work of Bion (1961) and Ezriel (1956–57). With this approach, the therapist's attention is focused on the transference, i.e. the conscious and the unconscious relationships that the patients make with the therapist and with each other in the here-and-now of the group interaction. The group is allowed to develop spontaneously and the therapist uses the content of the discussion and the behaviour of the group to bring out:

(*a*) The conflicting feelings and motives expressed within a common theme, such as anger with the therapist or longings for a special, intimate relationship with him, along with inhibiting fears such as rejection by the therapist or humiliation before other group members.

(*b*) How each individual tries to deal with the common tensions underlying a topic, i.e. the particular defences adopted.

II. Data

Typescripts based on tape-recordings were available for the 2-year period when the group met behind the screen as well as for ten additional sessions after it had moved from the screen room into the therapist's office where no observers were present. The typed records were read independently by the two investigators, and all instances were noted where either a manifest or a latent reference to the screen was made by any member of the group

or by the therapist. There were, in all, thirteen such references, each of which has been summarized below, along with an abridged account of the context in which it occurred. There are also brief notes on the general happenings within the group during the intervening periods. Every summary is followed by brief comments in which are indicated the significant points emerging from each instance.

Sessions 1–5 (*October–November*)

In the early weeks the group was absorbed in learning how the sessions would be conducted and in getting to know and trust the therapist and each other. A woman member (Miss S) became a preoccupying concern because her compulsive monopolizing of attention and aggressive nagging were difficult to tolerate or alter. Competitive feelings for the therapist's attention with consequent fears of rivalry and of unsympathetic attitudes from other members emerged. At the end of the second meeting Miss C asked for a private session to discuss something which she could not bring out in the group. She was told it would be better to try to bring it up there. During the next few sessions she started a practice of sitting beside the therapist where in addition to being close to him she had her back to the screen.

Reference 1. *Therapist's initiative. Session 6. Miss B absent*

Towards the end of session 5, the members had discussed whether or not they were a group. Miss C was most expressive of her feelings in saying they were not a group: '...everybody is a separate entity who is only interested really in their own problems.... I don't feel part of a group at all.' In response to a comment by the therapist about the members' need to be accepted and loved by him, she stated that she was getting into a 'state' and that she did want to be loved by him.

At the beginning of Session 6 a member pointed out how Miss C had turned to the exit door instead of towards the therapy room. Miss C

remarked it must have been automatic and invited the group to discuss it if they liked. The group, however, ignored her and took up a suggestion that they should use Christian names. This move towards achieving some degree of group cohesion did not last because of Miss S's need to control the proceedings. Later the group became concerned with the way in which strong feelings such as depression and inadequacy tended to overwhelm them and here again Miss S took the lead in exploring these feelings and in questioning others about them.

The therapist commented on how the group members reacted ambivalently to Miss S. On the one hand they resented her need to monopolize, but on the other they colluded to put her into this position. He went on to interpret the role of each member in some detail and in connexion with Miss C referred to her difficulty in feeling a part of the group and her concern over not getting his exclusive attention. Perhaps, too, she felt he was more interested in people behind the screen because she had made a point of sitting close to him with her back to the screen. This reference to the screen was not taken up by any member of the group during the rest of the session.

Comment

In this session the therapist took the initiative in referring to the screen. This arose partly from Miss C having reacted strongly in a preliminary inquiry on possible objections to joining a group which would be observed through the screen. She had then stated that she would be worried about being watched but would accept the situation. In addition, she insisted, rather assertively, on taking the chair next to the therapist, and the one with its back to the screen. She had sought a private interview with the therapist and had declared that she did not feel a part of the group, implying that the other group members (and perhaps also the observers) were in the way of her securing a relationship with the therapist.

The reference to the screen was brought in as a part of a comprehensive comment about the group theme and the role of each member in it. The group members seemed too pre-

occupied with what was going on inside the group, particularly their feelings about Miss S's domination, for the observers to become a theme of immediate concern.

Sessions 7–20 (November–March)

The hostility to Miss S gradually became more open, as also did the group's collusion in allowing her to continue her domination as the 'controlling mother'. After she left (Session 15), there was a good deal of guilt worked through over her departure.

Rivalry situations and social difficulties then began to be discussed more directly. Miss C frequently described the triangular situations she got into with other women in her office over their relationships with the boss. The nature of the sexual conflicts in the group became more manifest and fears of uncontrolled sexuality began to be expressed.

Reference 2. Therapist's second reference. Session 21. All members present

In the previous session, the last before a holiday break, Miss O had told the group about a novel she was writing. The story depicted a near-incest situation, in which a man and woman fell in love without knowing that they were a brother and sister who had been separated. Later in the same session dependent feelings of several members, aroused by the break, became prominent. The next day Miss O had such tense feelings that she called the Clinic to ask if the therapist could see her but this was not possible.

In the first session after the break Miss O referred to her disturbed episode and later the group went on to discuss the incest theme in her novel. A few members brought memories of Oedipal phantasies from childhood. The therapist pointed to the disturbing thoughts and feelings associated with the incest theme and suggested that the group was perhaps resentful with him for exploring them as well as for heightening such feelings by the break.

Following these comments, there was a short discussion about the significance of the break. Then Miss C mentioned her difficulty in participating in the discussion about incest. She went on to describe her worries about a party where

'people will talk about subjects that are beyond me'. The therapist pointed out that her difficulties and worries seemed to relate to the incest theme. This was illustrated by the fact that right from the start of the group she had wanted to have a special relationship with him, e.g. she came and sat beside him in every session. There she sat with her back to the screen, perhaps to forget the observers and to cover up her guilt.

The therapist's reference to the screen was completely ignored by Miss C and by the group during the remaining twenty minutes of the session, and there was no reference to it in the next session.

Comment

The holiday break had increased the tensions arising from the Oedipal phantasies. The resistance to recognizing the sexual longings underlying these phantasies was particularly striking in the case of Miss C, the patient whose acting out of the Oedipal situation in the group had begun to irritate the other members. This second reference by the therapist to the observers was intended primarily to breach her massive resistance to recognizing her need to be 'the boss's woman'.

The group ignored the reference to the observers and remained preoccupied with the impact of the incest theme. To have allowed the screen to assume importance, even had its significance been restricted to Miss C, would presumably have meant admitting embarrassing sexual phantasies about the therapist in the here-and-now situation.

Sessions 22–29 (April–June)

Angry frustrated feelings with the disappointment over magical expectations about treatment became more open. Mr W brought the problem of having become attached to a girl who was homosexual. Oedipal rivalries within the group, in triangular conflicts outside and with inner parental figures, now featured prominently. In Session 29 Mr W surprised everyone by describing a period of several days in which he had experienced a striking change in himself, viz. affectionate longings for the therapist along with com-

pulsive locking of cupboards, turning off of taps, etc. The homosexual nature of these feelings and his defences against them were interpreted and discussed.

Reference 3. *Miss O's anxiety about observers.* Session 30. *All present*

Discussion developed on the theme of how people draw attention to themselves, Miss O described an amateur dramatic group in which she was passed over when parts were being allocated. Interest continued in the question of how some people grab the parts while others are left out.

The therapist interpreted that they were expressing their own competitive feelings in the group. In the subsequent discussion the rivalry theme was dropped and several members began to talk of their feelings of depression and inadequacy. Miss O said at this point that she knew that some of her colleagues might be coming to the Clinic as part of a social work course. She would hate to have colleagues listening and would be relieved if she were forewarned. In discussing her feelings, some members remarked that it was extremely unlikely that her friends would be there. Miss O stated she really knew this, but she still had a strong feeling of being watched.

The therapist remarked that the concern about the observers stemmed from a fear of humiliation and punishment which were appropriate to wanting a special relationship with him at the expense of the others. The interpretation was followed by some remarks about how they hated being laughed at, Miss O adding, 'especially behind my back'. The therapist commented, amongst other remarks, that Miss O seemed to feel that if she brought her longing to him, he would go off with the people behind the screen to laugh at her. Miss O said that she had often wondered whether any observers were actually there, and another woman replied that one night they were heard laughing behind the screen. One of the men (Mr L) added in a casual way that the only thing to do was to develop a sense of humour. A third woman (Miss B) said she did not bother about the screen and asked if this was a peculiarity of hers. Mr T remarked, with obvious tension in comparison with the others, that she was very lucky not to care and Miss O wondered if she was pretending to herself about this indifference. It

was said that if the people behind the screen did laugh at them they would be very unprofessional. Mr T commented that when they felt inadequate, other people might not really be laughing at them at all and added 'Somebody might have fallen off the chair in there' (i.e. behind the screen).

Comment

The questions of interest are why one member brought in the observers and why, in contrast to the previous references, they became the object of the group's concern.

Miss O's introduction of the screen presumably represented a displacement of anxiety caused by rivalry with members of the group to external rivals, since to continue the discussion with direct reference to her interest in the therapist would have brought into the open the painful rivalry situation in the group. The group's response to the observers indicated a sharing of Miss O's need to displace anxiety from the group to the feared rivals outside. In the early part of the session, there had been a withdrawal from the longings for the therapist (the sexual aspects of which had been commented on by the therapist at this period), and the group had shared the feelings of inadequacy which the sensing of the inevitable frustration of these sexual longings had brought—'there would be no good parts in the play for them'. By using the observers rather than the other group members as the rivals, Miss O provided them with a new opportunity to express their rivalry. For most of the group, however, the thoughts and feelings they described themselves as having in relation to the observers were more influenced by reality than was Miss O's phantasy-determined image of them.

Reference 4. *Mr L's phallic phantasy about the microphones. Session 31. All present*

A discussion started about Christianity, morality and sex, and the questions of freedom and control in sexual matters were then taken up. The therapist commented that the group was anxiously concerned about what would happen if sexual

thoughts and feelings were to continue to be freely aired without the group observing the various taboos and prohibitions.

After a brief silence, a group member asked Mr L if he had any views. Mr L said that he was sorry, his mind was distracted and, pointing to the microphones, he added: 'Actually I was wondering what on earth these two balls hanging there are. I am sorry I was not paying attention. Perhaps they are phallic symbols.'

The group ignored Mr L's reference to the microphones and went on to discuss further the questions of religion, sex and morality.

Comment

Although the microphones were obviously there to let the observers listen, Mr L's response to them was, as he himself implied, more to be related to sexual phantasies stirred up by the discussion than to the observers with whom any manifest connexion seemed remote. The directly sexual nature of his reference may also suggest why any latent feelings the group had about the observers had to be suppressed. Sexual feelings could only be brought in as a general topic and, moreover, in the context of how they should be regulated. For the observers to have become an open concern in this context would have meant the expression of sexual thoughts about the therapist and possibly sexual phantasies about him and the observers—themes which were only beginning to emerge and to which there was still strong resistance.

Reference 5. *Miss O's implication of continuing tension over the microphones. Session 32. All present*

As the group entered, they talked of how they tended to sit in the same places. After they sat down Mr W noted the fact that they had all taken their usual seats and Miss O and Miss B agreed that they had. Miss C, however, asked if Miss O was sitting in her usual place and Miss O answered that she preferred the seat she had, though as a rule she came in too late to get it. Miss B remarked that it was much more comfortable in the waiting room and Miss C added that perhaps the chairs in the waiting room were more comfortable.

Miss O pointed to another difference: 'No microphones there'. After a brief silence one of the women (Miss B) said that the group ought to continue the discussion started in the waiting room.

The therapist commented on how they had preferred the waiting room, including Miss O's observation on its lack of microphones, to the therapy room where he exposed their secret sexual phantasies.

The reference to the observers was not taken any further by the group.

Comment

It was again Miss O who made the second explicit reference to the observers. Strong rivalry feelings had become apparent in the discussion about seats. Miss B wanted to get away from these unpleasant rivalries by her reference to the pleasanter atmosphere of the waiting room. Miss O, also wanting to avoid group rivalries, attempted to displace her resentment on to the observers. For Miss B the observers were too close to the group situation to be allowed into the discussion, so she again brought in external situations.

With regard to why the group did not take up the observers as a common theme on this occasion, it may be noted that there had recently arisen anxious and aggressive feelings resulting from the frustration of repressed sexual wishes towards the therapist, especially amongst the women, and their anger had been displaced to external situations. To have become more openly resentful of the observers and their presumed relationship with the therapist would have entailed too explicit a confrontation of their guilt-laden sexual longings for the therapist, their dangerous hostility to the 'rival woman' (the observers) and their humiliated position as rejected 'little girls'.

Sessions 33–47 (July–November)

More intimate feelings were now pressing for expression with associated anxieties about how these feelings would be received by the group. During this phase dependent longings also became more prominent. The frustration of these longings began to be expressed in lateness, apathy and despair. Oedipal dreams and some Oedipal acting out formed much of the content with the open expression of sexual phantasies.

Reference 6. Miss C's reference to the higher microphones. Session 48. All present

During the first few minutes Miss C was the only woman present with two men. Her opening remark was: 'The microphone is higher tonight', but there was no response from the men. After a short pause she continued, 'I came in feeling very depressed. I feel a bit more cheerful since I arrived. Must be me.' There was again no response to her remarks and she went on to refer to her depressed fits. One of the men rather ostentatiously ignored her by proceeding to discuss with the other man the reasons for the latter being absent for several weeks, and the other members joined in when they arrived. For the rest of the session, the discussion was mainly about the size of the group, a theme stimulated by the fact that in this session all members were present after a few weeks of smaller attendances. Some felt better that everyone was around, others felt that more got done when there were fewer people in the group. The whole group became interested in the issue of crowds, how one avoided them, and how one asserted oneself in them.

Comment

Miss C's early reference to the microphones was, at the manifest level, associated with her depression. The instruments were at most only a few inches higher than usual, yet she appeared to associate this stimulus with a lightening of her depression. With no further elucidation it was not clear what the symbolic connexion with her relief was. Possibly it was a feeling that the 'persecuting mother' was further away, a relief that may also have derived from the fact that the other women were absent at the start.

The lack of group response to the microphones in this session seemed predominantly related to the intense triangular situation in

the group. One of the men was particularly hostile to Miss C at this period and expressed this feeling by his deliberate ignoring of her. The other man present at the start was also critical of her. The subsequent discussion about the size of the group revealed the continued presence of rivalry feelings in the group.

Sessions 49 and 50.
(Second year—November to Christmas break)

There were several references to outbursts of anger with bosses and parents which were associated with the coming Christmas break. Mr W, who had been abroad for some weeks, returned in Session 49. The group members made no comments about his return and later he tended to be contemptuous of the therapist's reference to dependent feelings. He thought he would now give up the group or might well do so after the break. He did not come to the last session before the break and 3 days later he arrived at the Clinic in considerable agitation. As the therapist was unavailable, he was seen by another doctor.

Reference 7. Mr W's disguised reference in a vivid dream. Session 51. Mr T absent

It was the first group meeting after the break. Miss O talked of her dependence upon her mother and whether or not it would be possible for her to live separately from her. This theme was kept going by others questioning her about steps she might take. The therapist interpreted that the group's interest in her dependence on her mother expressed their own feelings of dependence, as stirred up by the break. This led Mr W to talk at great length about his vacillation between attitudes of independence and dependence. In this context he related a dream which he had had before Christmas and which he said had greatly disturbed him. In it he was attending a ceremony in the chapel of a university where he was employed. At the end of the commemorative sermon a group of 'mass observation observers' turned up to ask the university staff questions about the brands of tea, coffee, wine, etc. that they drank. Mr W objected to the introduction of this commercial element into a religious function and refused to

answer any questions. The secretary of the university got annoyed and asked him to quit the job. Mr W begged and cried but to no avail, so he decided to kill the secretary by using a long case-opener and then to poison himself before he was caught.

When he finished telling his dream the group members started discussing Mr W's attitudes of independence versus dependence. Miss C soon interrupted to tell the group about a quarrel with her landlady who had let people move into her room to redecorate it without obtaining her permission, or even informing her. She talked of her anger with the landlady about this intrusion, and there was some discussion of how this kind of incident should be handled.

The therapist's interpretations focused on the group's dependent feelings as related to the break; thus, the two women spoke of angry 'mothers' intruding on them, while Mr W resented the university secretary bringing him to the chapel and then subjecting him to a mass-observation quiz. Mr W perhaps felt that he was merely another 'case' for the therapist to play with in front of the screen.

The group did not take up the interpretation but went on to discuss Miss C's episode with the landlady and a similar humiliation experienced by Miss O at her work. There was no further allusion to the observers.

Comment

Mr W's upset before the break had revealed a large breach in his habitual rigid defences. On his return from his trip abroad he must have felt rejected by the group as well as by the therapist, and at first he tried to deny these feelings by professing independence to the extent of believing he could do without the group. Missing the last session appeared to be a defiance of the therapist, who had been stressing the group's dependent feelings. In keeping with his strongly defensive detachment, the breakthrough of his feelings for the therapist on the night of his defiant absence could appear only in disguise in a dream.

There was no general response on the part of the group to the observers. Instead the discussion switched to external incidents, and the turning away from Mr W's experience was

striking. This move away from his experience could be viewed as an attempt to escape from the intolerable dependent feelings for the therapist. To have taken up Mr W's dream and the links with the depriving observers would probably have confronted the other members with conflicting feelings about the therapist which were too painful.

Sessions 52–56
(Second year: January–February)

Delayed resentment about the break and dependent feelings began to be expressed in the form of increasing references to depressed feelings which derived from the release of destructive phantasies towards the frustrating therapist (parent). The strong feelings for the therapist, bosses, and parents required a good deal of working through before these feelings could be accepted. In Sessions 55 and 56 there were several expressions of resentment with members for taking up too much time.

Reference 8: Miss O's anxiety over the unknown observers. Session 57. Mr L absent

The session started with Miss C coming alone into the room ahead of the others, followed soon by Miss O, who also preferred to walk ahead while the others were waiting downstairs for the elevator. This was in some contrast to the usual practice of the group, which was to come to the room together.

Miss O said that coming to the group made her anxious that evening. She found it hard to talk of a certain problem from her past. If she failed to bring it up in the group she would have to ask for a private session with the therapist. Several group members tried to persuade her to talk of it in the group and she eventually remarked: 'I don't mind the lot of you being here but goodness knows who is behind the screen, people I might get involved with in my work.' The group then attempted to reassure her about the observers, by such remarks as: 'You have talked about so many things with the other people behind there that it should not matter any more.' 'They can be big-hearted enough to realize that all flesh is human.' Despite these pressures, Miss O said she did not think she could get it out.

The therapist then pointed to the collusion between Miss O and the rest of the group in developing a situation of coaxing her to speak. They all had feelings that they did not wish to talk about and by fastening on to Miss O they were trying to treat these reluctant bits of themselves.

Following this interpretation Miss O readily described her concern about a homosexual phase in her adolescence and its recurrence in her twenties after a broken engagement. The 'analysis' (as she referred to the sessions) had brought this worry about the past back again. The whole group then became absorbed in the theme of homosexuality.

The therapist commented that Miss O was turning to homosexuality as a result of disappointment and frustration with the male therapist. He also pointed out how the group's interest in continuing the discussion on this theme revealed their own concern over similar feelings towards the therapist. He went on to interpret the interest in the people behind the screen as representing their curiosity about 'the other parent'. The reference in this interpretation to the observers was 'ignored' by the group in their subsequent discussion, which concerned Miss C's description of a new feeling she had experienced in the last week or two, namely, an aversion to men.

Comment

Miss O's anxieties about her unconscious drive to get the therapist's exclusive interest had apparently stirred up her dread of the rival 'mother' and also her homosexual solution to this situation. The danger of rivals within the group was still too great to bear and led to a displacement to the observers, her phantasy again being that her colleagues would be watching her.

As long as the group felt the observers were being discussed only in relation to Miss O, they gave expression to their feelings about them. When the therapist interpreted later on that the group shared the homosexual phantasies to which Miss O had turned as the result of disappointment with the male therapist, then interest in the observers ceased. To have continued would presumably have meant being

confronted with homosexual phantasies in the here-and-now of the group and they preferred instead the less direct expression of feeling by talking about incidents outside the group.

Sessions 58–62 (March–April)

The freer communication of phantasies about the therapist led to a more active interaction in the group. Guilt and anxiety related to early parental memories appeared.

Reference 9. Mr W's second dream. Session 63. Miss C absent

It was the second last session before the Easter break. At the beginning of the session Mr W brought up a dream in which he was a child taken to a doctor by his mother. 'The doctor got out a stethoscope and proceeded to put it against me, but instead of putting the other ends in his ears—the two sort of earpieces—he plugged them into the wall....I said to my mother, "This man is a phoney I don't believe he is a doctor at all...." I said, "Well, I know a doctor who is better than that..." having in mind Dr Sutherland...and then, as we were walking along, much to my surprise, I saw you, Dr Sutherland, on the other side of the street....I waved to you several times but you were so busy examining the house numbers that you took no notice of me.'

The group went on to discuss various aspects of Mr W's feelings towards his mother, his father and the therapist. The therapist interpreted that Mr W and the other group members felt the coming break as a rejection. They were all interested in Mr W's dream which presented two versions of the therapist: 'There is one who hides behind all the paraphernalia of medicine, the "me" that you feel resentful with, because I am inhuman, impersonal. I plug the stethoscope into the wall...it sounds like some reference to the observers or to the fact that I am just using you as specimens, that they can watch your feelings, as it were, or listen in to them....The other "me" that Mr W was trying to get at was also rejecting because I seemed to be so concerned with all the other members and missing him. This feeling too was similar to one Mr W had brought in his dream at the time of the Christmas break.'

The interpretation was followed by a long silence. The therapist commented that the thick silence was perhaps due to his having raised the question of dependent feelings and that the group seemed to be making a concerted effort to sulk and to have nothing to do with him.

The group again ignored the therapist's comments and went on to discuss one of the women's (Miss O) feelings of inadequacy and depression when rejected as a child by a school teacher.

There was no mention of observers in the remaining part of this group session nor in the next.

Comment

This session was reminiscent of Session 51, when Mr W described his first long dream. Here, too, his feelings about rejection were stirred up by the break, and again they appeared in a vivid dream. On this occasion, however, Mr W's experiences were not ignored. The group explored them in considerable detail, but as though they were something external to themselves. There was no reference to the observers, because it might not only have brought in the humiliated rejected feelings but also anger and resentment over the rejection, feelings which would have created too much anxiety.

Sessions 64–66 (April–May)

Depressed feelings concerned with hostility towards the rival Oedipal parent developed and hostility continued to Miss C for her chronic tendency to monopolize the therapist's interest. Mr T, who had said he might not continue, evoked a good deal of pressure from the others to stay.

Reference 10. Mr T's anger. Session 67. Mr L absent

The group members began by inquiring after Mr T's difficulty in bringing up his problems for discussion in the group. The therapist commented that their great enthusiasm to get Mr T to speak was a substitute for speaking about themselves and especially for expressing their resentful feelings to him and to each other. Mr T said that

he was angry because he was forced to struggle in order to get to the group on time, because he had to travel a long way, give up an evening, and so on. He needed to come but he resented the position of having to come. He added that he resented most the therapist, because he was the head of the group and, to him, the 'instigator'.

The group showed surprise at finding in Mr T a strong need to come to the group as it had been their impression that he had no such need. The therapist pointed to the similarity between Mr T's feelings about the group and the feelings of a child towards its parents. One cannot do without parents. One is furiously angry with them at times, yet one is tied to them and continually hoping for something better from them. When Mr T was asked by other members what it might be about the group situation that he resented so much he answered: 'Merely that I am forced into this position of having to come here. It seems to me to be humiliating...I know Miss O is always worried about her friends being behind the glass and so on, and I sense other people are too.'

The group ignored this reference to people behind the screen and continued instead to discuss Mr T's angry feelings towards them as well as towards the therapist.

Comment

Although in the past he had reported that attendance at the group had made him aware of intense pent-up, angry feelings, this was the first occasion on which Mr T brought them directly to the therapist and the group. Just as the fears of what his angry feelings would do had led to his keeping away, so now, when eventually brought to the group, he could only allow them to be directed at first towards the therapist. It seemed that he could not include the group in the angry feelings he revealed towards the therapist, and had to bring in the observers in place of the group members as more remote objects of his hostility. The group, however, inferred from his past aloofness that he also resented them and began to question him about these feelings.

Reference 11. Miss C faces screen. Session 68. Mr L absent

Mr V came in first and took the seat next to the therapist. Miss C, who normally occupied it, took a chair facing the screen, smiled at Mr V and remarked 'A switch around—it feels funny facing the screen—it is the first time I have faced the screen for about a year—I feel self-conscious now'.

Miss C next asked Mr V why he had taken her chair. He did not know and inquired whether she felt it was her chair. She answered that she did, and then went on to describe a dream in which she was travelling in an aeroplane with her family and fighting as if for her life with the feeling that the plane was going to crash. The therapist commented on the fight going on in the group itself. He recalled Miss C's concern about being watched from behind the screen and made some further comments about her need to monopolize him. The group ignored the mention of the screen and went on to discuss their inter-relationships.

Comment

Here again Miss C seemed to use the observers for the displacement of her hostility from the group. Her resentment was primarily with Mr V for taking her usual chair. The group felt resentment with her and preferred to take up their inter-relationships more directly.

Sessions 69–80 (May–October)

Anger and frustration with the therapist over disappointed Oedipal longings and Oedipal dreams continued to be worked through. The homosexual solution of Oedipal rivalries and at times the aggressive manifestations of rivalry in the group became more intense. The summer break on this occasion was 2 weeks longer than usual because the therapist had to be abroad. This fact probably contributed to its provoking stronger feelings than hitherto, with denials at first and then recognition of the role of the dependent longings.

When the reactions to the break had been discussed, the therapist announced that the group would end its period in the screen room

and change to his office in 2 weeks' time. There was no response to this announcement until the end of the last session before the change, when on his reminding them of the new room for the next week's session, one of the men (Mr V) asked if that meant the group would no longer be observed.

Reference 12. *Change from screen room. Session 81. Miss C and Mr T absent*

The members did not arrive together and, unlike the usual pattern, the therapist said 'Good evening' to each member individually as they entered his office, and then inquired after the health of one of the men who had been ill. Mr V thought the therapist was 'slightly more personal' and that the room had a certain air of domesticity. Miss O reflected: 'I am wondering whether the sort of pictures and basins and things are going to be distracting.' While the group was engaged in noting the differences in the therapist's attitude and in the two rooms, Mr V pointed to the additional difference that there were no more people behind the screen.

Miss O said she would have feared being observed by a group of social workers visiting the Clinic that evening (actually a group attending a seminar). Mr V had seen a girl from his office in the Clinic and there was a brief discussion about his concern lest she be admitted as a patient in this group. The therapist commented on the fears about being watched coming, as before, from inside themselves, perhaps increased by the feeling of a closer relationship with him. When they were free from the screen observers, the watchers still came in, colleagues from a course or people with whom they worked.

Miss O said that the new group room was on the same floor as the old one, and that coming here involved the same number of floors on the lift. She went on to say that her claustrophobia was as bad as ever and the group got engaged in discussing her symptoms. The therapist commented that despite the new room the group were finding themselves up against the same old symptoms and difficulties.

Mr V described feeling depressed about his work situation as he had been unable to get away from his malevolent boss to a more satisfying job. Miss B discussed her difficulty in deciding whether or not to take a certain part-time study course.

All this time Mr W had been very quiet 'because I am sleepy'. The therapist pointed out how the various group members, in talking about indecision with regard to taking a study course or changing a job, or in feeling withdrawn from the situation, seemed to express their concern about continuing to attend the group, feeling perhaps that the therapy course was not worth it.

After a long silence one of the men who had been very quiet (Mr L) re-initiated the discussion about the change in the therapist's attitude, viz. the intimate and friendly feeling that had been present at the start. The therapist commented that as he continued to make the usual kind of interpretations, the wishful thinking for a more friendly therapist with the change of room had receded, and that they now wished to recapture this close relationship.

Mr L remarked on how the therapist reminded him of his father. He added: 'The more you love them, the more you fear for them that something may happen, that in some way the relationship may be broken.' Mr V pointed out that concern about someone's safety often concealed a wish for his death. Next, Mr V described how at the moment he was '...very conscious of the outside world in this room, of people creeping about upstairs and laughing and fooling around in the corridors. I seem to be much more conscious of them here than I was in the other room...'. The group went on to discuss the differences in quietness and in privacy between the two rooms. Then there was a long silence, which was interrupted by one of the women (Miss B) raising once again the problem of her inability to decide whether or not to join a study course. Mr V commented irritably that he could not focus his mind on the kind of problems that she presented and blamed her for bringing in extraneous issues.

In his next interpretation the therapist pointed out how the group's expectations in the new room of finding in him a more affectionate, a more loving, father-like figure were frustrated when he did not conform to this role. The group had felt at the beginning that he was more intimate, more personal, but were later disillusioned when he continued to play the same old role. There was concern about losing him, which Mr V felt might represent an expression of anger and a wish for his death. In his reference to people creeping about outside the room, Mr V was perhaps revealing his fear that some retaliating figures

would open the door and interrupt the close relationship they wanted with the therapist.

There was no further mention of the observers in the remaining part of the session.

Comment

On this critical occasion of the group's move from the screen, a striking feature was the transience of 'relief' feelings. The new room, with its more personal furnishings and the more friendly greeting of the therapist, reinforced the longings for a more intimate relationship with the therapist. These forbidden longings, however, soon reactivated the inner fear of rivals, with the result that the initial good feeling of closeness to the therapist gave way to increasing tensions about 'inner observers'. Thus Mr V, who was the first to comment on the newly found intimacy, had to note that the external observers were absent, and soon afterwards he gave more direct expression to his fears about observers by describing his concern about a colleague joining the group. Miss O also showed a similar fear in her comments about her colleagues.

After Mr L had reverted to the earlier theme by declaring his strong feelings for the therapist, it seemed that Mr V's phantasies of the dangerous rivals in the group were intensified but displaced to potential intruders from the corridor outside the room. The limited success of this manoeuvre was seen in the irritability that he expressed towards Miss B for her attempt to divert the discussion to external incidents.

Reference 13. Curiosity about screen room. Session 82. Mr T absent

Miss C, returning to the group after her holiday, started to describe fits of acute depression she had had recently. She then mentioned that she had walked into the old room. Miss O admitted having waited near the observers' room and added that she was 'dying to peep and see what was going on'. Mr V reported that he too had

looked into the observers' room where a film was being shown and so he had quickly withdrawn. Miss O then confessed that she had actually looked into the room and was surprised to see it in darkness.

Miss C reverted to her depressed feelings and described how she had felt isolated from her companions on holiday. The discussion about her feelings continued for some time and Mr V observed that the group had become very depressed—'everyone is looking as if they were going to burst into tears'. Shortly afterwards, Mr W noted the apparent contradiction between what had been happening to Miss C on her holiday and the way in which she was monopolizing interest that evening. Several members went on to compare the amount of attention that she was able to command in the group with the little recognition she got from others on her holiday.

In his interpretation, the therapist referred to the group's depression as being intensified by the feeling that the new room had not changed anything. The depression had in turn led to their concern about Miss C, who seemed to represent for them a mother inside the group who had taken possession of the therapist.

There was no further reference to the observers in this or in subsequent sessions.

Comment

Miss C's going to the old therapy room was perhaps due to the fact that the change of room had occurred when she was still on holiday, but the entry of Mr V and Miss O into the observation room clearly stemmed from their intense curiosity about the observers. The unconscious motivation behind their curiosity could have involved a variety of phantasies which remained unexplored. It was clear, however, that there was an element of latent excitement in their phantasies about what went on behind the screen, as though they felt they would now share the same special relation with the therapist as the observers had done formerly. This excitement died down rapidly with the realization that the possessive mother (Miss C) was back in the group to deprive them of the therapist.

III. DISCUSSION

General effects

The first point to emerge from the data is the limited number of references to the screen. The ninety group sessions reviewed, covering a period of more than 2 years, produced no more than thirteen screen references, seven of which were limited to single comments by individuals and evoked little response from the other group members. The group's reaction to the screen remained minimal, in spite of the fact that the therapist was particularly interested to point out any significant impact of the screen on the group, and in fact had taken the initiative in the first two instances to comment about the seat taken by a group member in relation to the observers behind the screen.

It would thus appear that the screen did not constitute to an appreciable extent either a constant source of distraction or a persistent cause of inhibition. What happened instead was that occasionally a group member would complain of distraction (Mr V in Reference 12) or of inhibition (Miss O in Reference 8 and Mr T in Reference 10). All such episodic complaints could be understood in terms of the dynamics of the situation at the time and are best seen as equivalent to other sources of defence or resistance during psychotherapy. Mr V's distraction by 'people creeping about ...in the corridors' represented a resurrection of the observers (when the group had moved out of the screen room into the therapist's office) and conveyed his fear that a retaliating figure would open the door and interrupt his relationship with the therapist. Miss O's stated inability to talk of her problem in the group because of the presence of observers disappeared when the therapist interpreted the nature of her defence; she then proceeded to talk freely about her homosexual difficulties. Mr T's reluctance to speak because of people behind the screen was another instance where the screen was used as a temporary peg on which to hang his resistance, a resistance which was related to his major symptom of exhibitionistic anxiety.

It would therefore seem that when members of the group refer to the screen as either distracting or inhibiting, their references are best understood as a means of resistance and are as amenable to effective interpretation as any other significant feature of a psychotherapeutic situation.

While the screen could conceivably be used as a means of resistance in many ways, it is seen in this study that there are a limited number of typical forms that this resistance tends to assume. A common feeling is that it is difficult or humiliating to talk of personal problems in the presence of people behind the screen who are unknown to the patients, or who might judge them harshly or be unduly critical of their motives and behaviour. An allied concern is the fear that the observers might make fun of the patients' problems and difficulties, and that the therapist might join with the observers in laughing at them behind their backs. Another common reaction is to see the observers as stealing the therapist's attention away from the group, so that the patients feel that the therapist's interest in them is subordinate to his primary interest in teaching the observers. Along with such fears and anxieties, the observers are also made the object of interest and curiosity.

It would thus seem that the feelings projected on to the observers are typically those related to phantasies about the role of the other parent. The activation of the internalized conflict with the rival parent can be seen in References 12 and 13 when, in the absence of observers, the group members were unconsciously impelled to recreate the feared observers in a variety of ways.

It is clear from the data given in Section II that the group's concern about the screen could be expressed either in a conscious or in an unconscious form. The feelings about the observers in References 7 and 9 were manifested in the first instance through the relating of dreams. Miss C's concern about the intrusion of the observers was also revealed indirectly through her description of a quarrel with her landlady who had let people

pry into her room. In addition to these instances of indirect expression, an unconscious component could be seen in the more direct references to the screen also. For example, Miss O's stated inability to talk of her problem because of the people behind the screen in Reference 8 was shown to be unconsciously determined and projective in character by the ease with which she talked freely of her homosexual difficulties immediately following an interpretation.

Differential effects

The screen had an effect on each group member, though this differed in intensity as well as in mode of response, and was directly related to the particular character structure or symptomatology of each person. The response to the screen of two group members, Mr L and Miss B, was minimal. Mr L indicated his concern about the observers only once when, in Reference 3, the group were expressing their fear about being laughed at and he joined in to remark: 'The only thing to do is to try to develop a sense of humour'. His only other comment, about the microphones, in Reference 4, was ambiguous in meaning, suggestive more of sexual phantasies about the therapist than of any direct reference to the screen. Both of these comments are consistent with his character structure, a prominent feature of which is submission to the sexually potent and powerful father. Miss B never mentioned the screen herself, and when it was brought up she professed to be indifferent to it. In her lack of comment about the screen a process of defensive denial (in keeping with her major character defence of denial) was noticeable on more than one occasion: when the observers were referred to by other group members she manoeuvred towards external topics which led the discussion away from the observers. At one point, her attempt to deny the effect of the screen was noticed and pointed out by group members themselves (Reference 3).

In direct contrast to the minimal response from Mr L and Miss B, two other group members, Miss O and Mr T, showed intense concern about the screen. Miss O experienced recurrent anxiety about being watched by her colleagues. The reality basis for her fear was that she knew that some members of her profession attended seminars at the Clinic. It was entirely a phantasy on her part, however, that such groups would be behind the screen. Her concern about being watched became acute when her feelings of Oedipal rivalry were at their strongest. The Oedipal theme was a particularly dominant one for this patient and had appeared in her relationship with her mother over the last few years, following her father's death. It is of particular interest to note that after the group changed from the screen room, and when Miss O was no longer able to use the observers as her feared rivals, she developed an almost unbearable hostility to Miss C. She sought a private interview with the therapist to tell him that she had become friendly with Mr W, but that she could not possibly mention this when Miss C was present. It took many weeks before she was eventually able to discuss this intense rivalry.

Mr T expressed his anxiety about the observers in Reference 3 by his questioning of Miss B's stated indifference to the screen, and in Reference 10 by referring to Miss O's anxiety about being watched from behind the screen. Though less direct in mode of expression, Mr T's anxiety about the observers appeared to be as intense as Miss O's. The responses of both Mr T and Miss O seemed to involve a projection of persecuting inner figures on to the observers, a projection that was in keeping with the fact that both of them suffered from intense phobic anxieties, Miss O experiencing claustrophobic panics, and Mr T having attacks of anxiety in 'exhibitionistic' situations (e.g. in public speaking). The more intense reaction to the screen of these two members perhaps indicates the existence of a close link between symptoms of phobic anxiety and fear of screen observation.

Unlike Miss O and Mr T, for whom the phantasied observers were frightening, Mr W perceived them to be depriving rather than persecuting, and expressed anger about them rather than anxiety. His mode of response was also radically different, in that both of his references to the screen (7 and 9) appeared in a symbolic form in his dreams. He presented a highly defended intellectualizing front, valued his emotional independence from people, and continually expressed his contempt for the unscientific nature of the therapist's interpretations. However, his repressed longing to be loved by the therapist showed a striking tendency to recur in dreams at the time of breaks. For him the observers represented the other parent responsible for his deprivation. It is interesting to compare his mode of response to the observers with his initial statement in his letter of acceptance when the group was first proposed to him. He wrote: 'I would probably be interested in joining the group and I have no *conscious* objection to one-way screen' (our italics).

Mr V's response to the screen was somewhat similar to that of Mr W. Ordinarily, neither would initiate discussion about the observers and when someone else raised the topic, both of them would react to it at the reality level, making rational comments, such as 'It would be extremely unlikely...' that Miss O's colleagues would be listening behind the screen (Reference 3); or 'I wouldn't let that inhibit you from speaking' (again concerning Miss O's reluctance to speak because of observers in Reference 8). However, under conditions of heightened feeling, both showed intense reaction to the presence of observers. Mr W responded in a symbolic form through his dreams. Mr V experienced anxiety regarding the 'people creeping about...in the corridors' when he felt he had a more intimate relationship with the therapist and feared that some retaliating figure would come in to interrupt this relationship. His comment about the screen was consistent with his problem of repressed passive homosexual phantasies along with a great fear of the retaliating rival parent.

Finally there was Miss C, the one amongst the group who most strongly demanded a special relationship with the therapist. Right from the beginning she asked for private interviews (which were refused), and sat beside the therapist in a position that also enabled her to keep her back to the observers. When, before the start of the group, she was told about the screen she had shown sharp concern about 'being watched and listened to by an unseen audience'. In spite of this strong initial reaction, however, her later comments about the screen remained minimal. In the first two references it was the therapist who had referred to her usual sitting position in relation to the screen. In Reference 6 she had simply referred to the microphones being higher that evening. In Reference 11 she had been blocked from sitting beside the therapist and was left facing the screen, which prompted her to speak of her mild discomfort in that position.

Like Miss O, Miss C also had strong Oedipal transference feelings to the therapist. Unlike Miss O, however, Miss C engineered in the group (as she also did in external social life and work situations) a self punishment in which she got isolated and rejected by other group members. It would appear that under the circumstances, Miss C did not 'need' to bring in criticism of the observers; for her the observers were much more remote than her rivals within the group itself. The group, in turn, perceived her as striving to possess the therapist and to exclude them. It was perhaps in keeping with the group's perception of her as an immediate rival that on each occasion when she initiated a reference to the observers, the other members were unable to express their feelings about these more distant rivals behind the screen.

Effects on group process

The above examination of differential effects concentrated on the role of intra-psychic factors in determining the intensity

and the mode of response to the screen and pointed mainly to the differences existing among the diverse screen references. The effects on group process will now be considered in order to elucidate the role of interpersonal and group situational factors, and this will perhaps clarify the common or shared meaning of the group's concern about the screen as seen in the various references.

Among the group situational factors examined were: (1) the size of the group, i.e. the number of members present in each session, (2) the duration of time for which the group had been in treatment at the time of each screen reference, and (3) the time around the various holiday breaks. Of these, the size of the group showed no relation to the frequency of the occurrence of references to the screen. The duration of time since the start of the group appeared also to be unrelated to the frequency of references. *A priori*, it would be expected that most references to the screen would occur when the screen was first introduced, or when another change was made. References 12 and 13 in fact occurred when a change was made and the group was moved away from the screen room. However, reference to the screen did not develop into a group topic until Session 30. That the screen did not become a topic of concern to the group for so long was probably due in part to the following three factors: (i) The process of overcoming initial anxieties about the situation inside the group was relatively slow because most of the members were inhibited in making social relationships. (Of eight people aged 30–40, only two were married.) (ii) The unusual domination by one member (who left after Session 15) made the initial situation a particularly difficult one for this inhibited group to handle. (iii) The screen was present from the start, and by the time mutual knowledge and trust had developed it was part of a familiar setting.

The holiday breaks, on the other hand, were seen to be related to the references to the screen. A reference was judged to occur around a holiday break if it was made after

the therapist's announcement of the break, or if made during the group's first meeting at the end of the break. Out of the eleven relevant references (References 12 and 13 being a direct consequence of the group's move from the screen room into a non-screen room), only four occurred at a time other than just before or just after a holiday break.

The holiday breaks are perhaps significant because of their impact on the group's relationship to the therapist. The separation, or prospect of it, tends to heighten the group's longing for the therapist. This, in turn, tends to activate the internalized conflict with the rival parent, the observers constituting a convenient peg on which to hang the phantasies associated with the role of the rival parent. Disappearance of the therapist is felt perhaps as a triumph for the observers. When all members of the group seem to share a common deprivation in relation to the therapist, it is difficult to use any member within the group as a successful rival.

The impact of the holiday breaks upon the group's feelings towards the therapist leads directly to an examination of the nature of feelings prevalent in the group that tend to elicit a reference to the screen. These feelings were of two kinds: (*a*) feelings of dependence, or of frustration of dependent longings, and (*b*) sexual feelings associated with Oedipal phantasies and strong rivalries. The screen acts as a powerful stimulus when it becomes involved in phantasies about the therapist's relationship with the observers, who then assume significance as people having close links with the therapist and stealing his attention away from the group.

It is seen in the data given in Section II that most of the direct initial references to the screen were made by individual members in an attempt to displace the uncomfortable rivalry experienced in the group itself onto the observers. But whether or not other members took up the screen as a group theme depended on the presence or absence of certain conditions which are given below:

(i) The group are concerned with their relationship to the therapist.

(ii) This concern is expressed directly in the *here-and-now*.

(iii) The quality of their relationship to the therapist is triangular, in the sense that their frustration with, or deprivation by, the therapist activates phantasies about rivals.

(iv) The group are passing through a common or shared experience of their relationship to the therapist, so that all of them are in the same position and find it difficult to use members within the group as rivals.

To illustrate from the data, Miss C's attempt to displace the rivalry onto the observers failed in References 6 and 11 because the group were preoccupied with their perception of her as an immediate rival within the group itself. A similar situation existed in Reference 10 when the group were engaged in discussing Mr T's angry feelings directly in relation to them and the therapist, and they could not go along with Mr T's attempt to displace his anger to people behind the screen. In References 2 and 5, the screen failed to become a group theme because the group were unable to face directly the guilt-laden sexual phantasies about the therapist. In contrast, Reference 3 depicted the group as completely absorbed in discussing their feelings about the observers, since the group were concerned about their relationship to the therapist in the here-and-now, and shared common feelings of inadequacy, making it difficult for them to find a rival within the group itself.

SUMMARY

The main points emerging from this exploratory study are:

(i) A one-way screen does not appear to act as a constant source of distraction or inhibition for patients in a therapeutic group.

(ii) The feelings projected on to the observers are typically those related to phantasies about the role of rival figures.

(iii) The group's concern about the screen is expressed both in a manifest and a latent form.

(iv) The effect of the screen on each group member varies in intensity as well as in mode of response, and is related to his particular character structure or symptomatology.

(v) Reaction to the screen is influenced by certain factors in the group situation, such as holiday breaks, the significance of which can be understood in terms of their impact on the group's feelings towards the therapist.

(vi) The initial reference to the screen is often made by an individual member in an attempt to displace an uncomfortable rivalry experienced in the group itself on to the observers, but whether or not the screen becomes a group theme is a function of the following situation: The group members are concerned with their relationship to the therapist in the here-and-now, and are sharing a common feeling of frustration or inadequacy, making it difficult for them to 'seek' a rival within the group itself.

In short, the data from the study of one group suggest that a one-way screen acts as a projective stimulus, the significance of which is determined by both the intrapsychic and the interpersonal dynamics of the group situation.

REFERENCES

BION, W. R. (1961). *Experiences in Groups and Other Papers*. London: Tavistock Publications.

EZRIEL, H. (1956–57). Experimentation within the psychoanalytic session. *Brit. J. Phil. Sci.* 7, 29–48; and, in continuation, Reply to Mr Spilsbury, *Brit. J. Phil. Sci.* 7, 342–7.

Relationship between lung cancer, cigarette smoking, inhalation and personality

By DAVID M. KISSEN*

It is reasonable to expect that inhalation of cigarette smoke will provide greater exposure of the bronchi to potential carcinogens than non-inhalation. As Hammond (1961) has stated '...degree of exposure of lung tissue (and other tissues by way of the blood) may be more dependent upon depth of inhalation of the smoke than upon amount of tobacco consumed'. A direct causal relationship between cigarette smoking and lung cancer, therefore, should be reflected in a greater risk of lung cancer among inhalers than among non-inhalers.

In all age groups the percentage of deep inhalers of cigarette smoke increases sharply in proportion to the number of cigarettes smoked per day (Hammond, 1959; Todd, 1962). Nevertheless, as is apparent from the reports of the Royal College of Physicians (1962) and the U.S. Surgeon General (1964) on 'Smoking and Health', a direct association between inhalation and lung cancer has not been unequivocally established. Figures relating to inhaling habits of lung cancer and control patients are available for only a few of the many epidemiological studies—those of Doll & Hill (1952), Lickint (1953), Breslow, Hoaglin, Rasmussen & Abrams (1954), Lombard & Snegireff (1959) Schwarz, Flamant, Lellonch & Denoix (1961) and Spicer (1963). Spicer noted that the studies of Doll & Hill and Schwarz et al., as well as his own, show a significantly greater percentage of inhaling lung cancer patients than controls at lower cigarette smoking levels but not at higher levels. Some of the figures suggest the possibility (British Medical Journal, 1962) that

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among heavy smokers non-inhalers may have the greater risk for lung cancer. If certain parts of the bronchial mucosa, accessible equally to the smoke of inhalers and non-inhalers were especially vulnerable this, according to a note in the British Medical Journal (1962), might explain the anomaly. There is, however, no evidence to support this unlikely hypothesis. Nor has a satisfactory explanation been given as to why some non-smokers and light smokers develop lung cancer while many heavy cigarette smokers do not.

This paper reports the results of personality findings in relation to inhalation of cigarette smoke and quantity smoked with a view to throwing some light on the apparently anomalous findings. Some of the material reported here has been previously published in abbreviated form (Kissen, 1964 a, b). This paper contains fuller details and gives further findings.

SMOKING AND INHALING HABITS OF CHEST UNIT PATIENTS

The data for this paper were elicited during the course of psychosocial studies in lung cancer from patients aged 25 and over recently admitted to three hospital chest units for diagnosis and treatment. There was no special selection of patients but the units were chosen because they were known to admit a fair proportion of lung cancer patients. The interviewer was not responsible for diagnosis or treatment but attended for research purposes only. At the time of interview he was unaware of a diagnosis, nor was any patient aware of a diagnosis of lung cancer, whatever diagnosis had been given. Indeed at this stage in most cases a diagnosis of cancer had yet to be established. Those subsequently found not to have cancer served as controls. Females were

also studied but their numbers are too few for proper assessment.

The use of chest unit patients as controls for the lung cancer patients, in the objective manner indicated, ensures like environmental conditions and emotional motivation for the patients' co-operation, factors which if uncontrolled may significantly affect findings in psychosomatic studies (Kissen, 1964 c, d).

Nevertheless, such a control group of chest patients may be criticized because it may contain a large proportion of patients suffering from bronchitis, and a number of investigations point to an association between bronchitis and cigarette smoking. This could bias findings in personality studies in relation to smoking habits.

To ascertain the possibility of bias in the smoking and inhaling habits of chest unit male patients, figures were obtained during the course of another investigation by the same interviewer of the smoking habits of non-cancer non-chest unit (medical and surgical) male patients in the same hospitals and compared not only with the chest unit patients (cancer and non-cancer) but also with smoking figures for the general male public. Using Doll & Hill's (1952) definition of a cigarette smoker as a person who has smoked at least one cigarette daily for not less than one year

and by adjusting figures given by Todd (1962) to conform with a classification appropriate for this psychosomatic study, which includes ex-smokers among smokers, it was possible to estimate smoking figures for men aged 55 and over from the general public and these are compared with similar age categories of the other groups.

Smokers

It can be seen (Table 1) that both lung cancer patients and chest unit patients contain more cigarette smokers and fewer light smokers than do the general public and non-chest unit non-cancer patients.

Inhaling habits

An inhaler was regarded as one who gave an affirmative answer to the question 'Do you inhale'? Comparison was again made with the non-cancer non-chest unit patients and with figures given by Todd (1962). It can be seen from Table 2 that there are no suggestive differences between the percentage of inhalers in any of the hospital groups. Indeed, the non-cancer non-chest unit patients appear to contain most inhalers especially in the age group over 60. In this

Table 1. *Percentage distribution of male smokers aged 55 and over*

	Never smoked	Manufactured cigarettes daily			Hand-rolled cigarettes only or with pipe	Pipe only	Total
		1–14	15–24	25+			
Lung cancer patients	2·8	14·7	39·2	28·7	12·5	2·1	100·0
Other chest unit patients	5·2	21·6	37·1	20·6	7·2	8·3	100·0
Non-cancer non-chest unit patients	9·8	26·8	31·6	19·6	2·4	9·8	100·0
General public (estimated from Todd, 1962)	8·1	27·9	19·7	12·4	12·9	19·0	100·0

Table 2. *Percentage of inhalers among male cigarette smokers*

	Age groups				
	25–34	35–49	50–59	60+	All (25+)
Lung cancer patients	100·0*	87·0	85·0	82·0	85·0
Other chest unit patients	91·0	89·0	87·0	88·0	89·0
Non-cancer non-chest unit patients	94·5	92·3	90·5	92·0	92·2
General public (Todd)	92·0	89·0	81·0	67·0	82·0

* Only five cases.

age group the incidence of inhalers among the general public is lower than in the three hospital groups. There may be a number of explanations for this difference. For instance, might it be that hospital patients generally tend to inhale more or that there are more inhalers in this part of the country or that there are differences between the investigators in the manner or circumstances in which the smoking habits were elicited?

Attention is specially drawn to the higher proportion of inhalers in nearly all age groups in the non-cancer non-chest unit patients compared with the lung cancer patients. Since many studies used other hospital patients as controls this could explain the failure to find an unequivocal association between lung cancer and inhalation.

It should be noted that the number of chest unit patients included in Table 2 exceeded 800, of whom rather more than half were suffering from lung cancer. About half of all these patients were included in the personality studies to be described below.

LUNG CANCER AND PERSONALITY

Previously published findings by this writer on personality features of men with lung cancer (Kissen, 1963a, b; Kissen & Eysenck, 1962) form the basis of this report on inhalation. It is relevant at this point to give a brief summary of the pertinent features.

(1) *Outlet for emotional discharge*

After clinical appraisal of about 300 recently admitted hospital chest unit patients, half of whom were subsequently found to be suffering from lung cancer, the hypothesis was formed that *a characteristic personality feature of the lung cancer patient is a poor outlet for emotional discharge*. This hypothesis was then tested by two measures in about 400 chest unit lung cancer and non-cancer patients admitted subsequent to the preliminary appraisal. One measure used was the mean neuroticism (N) score on the short form of the Maudsley Personality Inventory (M.P.I.). This inventory, which has been extensively used and tested and shown to be reliable and valid (Eysenck, 1959), contains twelve questions, six to measure neuroticism and six to measure extraversion. The patient responds by circling 'Yes', 'No' or '?'. Each patient completed the

inventory at the end of the interview. None refused. The rationale for the use of this measure in these studies is as follows. According to Eysenck (1959) neuroticism refers to the individual's '...general emotional lability, emotional over-responsiveness and liability to neurotic breakdown under stress...'. This implies that neuroticism reflects ability to discharge emotional tension in one form or another. It would appear reasonable, therefore, to accept mean N scores significantly *below* 'normal' as reflecting emotional '*under*-responsiveness' and *less* liability to neurotic breakdown under stress and so indicate a poor outlet for emotional discharge.

The second measure, which might be more manifest to some, uses the incidence of certain random childhood behaviour disorders (C.B.D.) on the grounds that conscious or unconscious or actual absence of C.B.D., which are early manifestations of emotional discharge, might also reflect poor outlet for emotional discharge. The childhood behaviour disorders used were (i) bedwetting, (ii) fears, phobias, anxieties and sleep disturbances, (iii) stammering, (iv) trouble with authority because of truancy from school or trouble with the police, (v) temper tantrums. The responses were elicited by direct questioning before the completion of the M.P.I. All co-operated.

The results of both tests were consistent with the hypothesis, N scores and C.B.D. incidences being significantly low in the lung cancer patients. Moreover, there was a strong correlation between the two measures.

(2) *Extraversion*

As mentioned above, this is the second of two features measured by the M.P.I. and refers to the individual's out-going uninhibited sociable proclivities (Eysenck, 1959). Lung cancer patients were found to show a tendency to extraversion relative to non-cancer patients.

(3) *Concealment*

This feature, referring to conscious bottling up of emotional problems, was elicited by direct questioning. Lung cancer patients were found to show a trend towards conscious concealment of emotional difficulties. Among the non-cancer patients, however, such a trend was evident only

among those with a history of past psychosomatic disorder as compared with the group with no such history.

Differences in personality characteristics between men with lung cancer and the general cigarette smoking public (Kissen & Eysenck, 1962) showed that lung cancer patients are not a random sample of cigarette smokers.

PERSONALITY AND INHALATION

All the personality features referred to above were also measured in relation to inhaling habits of cigarette smokers in the lung cancer and non-cancer chest unit patients.

It will be noted (Tables 3 and 4) that in the series of 209 lung cancer and 178 non-cancer (controls) cigarette smokers there is a higher proportion of non-inhalers in the lung cancer patients and a lower proportion of non-inhaling controls than might be expected from the figures in Table 2, but there is nothing to suggest that this is anything other than a chance occurrence.

Statistical comparisons made in this paper involve the use of analysis of variance in which allowance has been made for disproportionate frequencies. Percentages have been transferred before analysis when appropriate (Snedecor, 1956). In the tables the numbers in parentheses indicate the total number in each group.

OUTLET FOR EMOTIONAL DISCHARGE

As indicated above, two separate yardsticks were used to measure this characteristic—the mean N score of the short form of the M.P.I., and the incidence of patients giving a C.B.D. history. For both measures the facility for emotional discharge in non-inhalers and inhalers is compared in terms of (i) age variability, (ii) quantity smoked, and (iii) psychosomatic history.

(i) *Age variability*

Figures for lung cancer patients and controls are given in Tables 3 and 4 respectively. Three age groups with mean N scores, standard deviation (S.D.) and incidences of patients with a C.B.D. history are given both for non-inhalers and inhalers.

Comparing lung cancer non-inhalers and inhalers

Analysis of variance both for N scores and C.B.D. incidences show (1) no significant interaction effect for age and inhaling habits on either measure, (2) an estimated difference in N scores of 1·25 points lower for non-inhalers than for inhalers (significant at the 0·05 level), (3) a lower C.B.D. incidence in non-inhalers than in inhalers (significant at the 0·001 level), (4) no significant difference between age

Table 3. *Outlet for emotional discharge in cigarette smoking lung cancer patients; comparison between non-inhalers and inhalers in age groups*

| Age group | N scores | | | | C.B.D. incidence | | | |
| | Non-inhaler | | Inhaler | | Non-inhaler | | Inhaler | |
	Mean	S.D.	Mean	S.D.	No.	%	No.	%
25–54	3·2	3·6	4·6	3·7	3	20·0	25	43·1
	(15)		(58)		(15)		(58)	
55–64	2·6	3·5	3·4	3·0	0	0·0	23	28·0
	(16)		(82)		(16)		(82)	
65+	2·0	2·0	3·9	3·9	1	12·5	9	30·0
	(8)		(30)		(8)		(30)	
All ages	2·7	3·3	3·9	3·5	4	10·3	57	33·5
	(39)		(170)		(39)		(170)	

Table 4. *Outlet for emotional discharge in cigarette smoking control patients; comparison between non-inhalers and inhalers in age groups*

| Age group | N scores | | | | C.B.D. incidence | | | |
| | Non-inhaler | | Inhaler | | Non-inhaler | | Inhaler | |
	Mean	S.D.	Mean	S.D.	No.	%	No.	%
25–54	6·2	3·6	5·3	3·6	7	70·0	42	50·0
	(10)		(84)		(10)		(84)	
55–64	3·5	3·6	5·1	3·8	3	75·0	23	40·4
	(4)		(57)		(4)		(57)	
65+	6·0	0·0	3·5	3·5	0	0·0	8	38·1
	(2)		(21)		(2)		(21)	
All ages	5·5	3·6	5·1	3·6	10	62·5	73	45·1
	(16)		(162)		(16)		(162)	

groups on the N score, but for C.B.D. the incidence in age group 55–64 is lower than in age group 25–54 (significant at the 0·02 level).

Thus in lung cancer patients non-inhalers have a poorer outlet for emotional discharge than have inhalers.

Comparing control non-inhalers and inhalers

The small number, sixteen, of non-inhalers among the controls makes statistical comparison between non-inhalers and inhalers less practical but the trend of the overall figures is in contrast to the lung cancer group, the non-inhalers having a somewhat higher mean N score and C.B.D. incidence.

Comparing lung cancer and control non-inhalers

Analysis of variance both for N scores and C.B.D. incidences shows (1) no significant interaction effect for age and diagnostic group (i.e. cancer, non-cancer) on either measure, (2) no significant differences between age groups on either measure, (3) a difference in N scores estimated at 2·5 points lower in lung cancer patients than in control patients (significant at the 0·05 level), (4) a lower C.B.D. incidence in lung cancer patients than in controls (significant at the 0·005 level).

Thus among non-inhalers lung cancer patients have a poorer outlet for emotional discharge than the control patients.

Comparing lung cancer and control inhalers

Analysis of variance for both measures shows (1) no significant interaction effect for age and diagnostic group (i.e. cancer, non-cancer) on either measure, (2) no significant differences between age groups on either measure, (3) an N score estimated at 1·0 points lower in lung cancer than in control patients (significant at 0·02 level) (4) a lower C.B.D. incidence in lung cancer than in control patients which, however, is not significant ($P < 0.1$).

Thus it appears that outlet for emotional discharge is also poorer among lung cancer inhalers than control inhalers, but the difference is perhaps not so marked as among non-inhalers.

Comparison with the mean N scores of Eysenck's (1959) standardization sample, $N = 6.15 \pm 0.08$, is of interest. The corresponding mean N figures for the control patients are 5.5 ± 0.9 and 5.1 ± 0.3 in non-inhalers and inhalers respectively. These scores are somewhat lower than the standardization sample, but near enough to be regarded as approximately 'normal'. The corresponding mean N figures for the lung cancer patients are 2.7 ± 0.5 and 3.9 ± 0.3 being well below the controls and standardization sample. These low scores in the lung cancer groups may be regarded as indicating

'under-neuroticism' and therefore a poor outlet for emotional discharge.

It can also be seen that both N scores and C.B.D. incidences, especially the latter, tend to be higher in the younger groups compared with the corresponding older groups. In the case of C.B.D. incidence this could be accounted for by the natural decline of memory with increasing age. In the case of N scores such an explanation is not applicable. N scores are also reported to be higher in the younger age groups in the standardization samples (Eysenck, 1959). The findings in this paper, therefore, suggest the possibility that outlet for emotional discharge may decrease with age.

These findings may be summed up by stating that a poor outlet for emotional discharge occurs in:

(a) Lung cancer non-inhalers compared with other chest unit non-inhalers.

(b) Lung cancer inhalers compared with other chest unit inhalers.

(c) Lung cancer non-inhalers compared with lung cancer inhalers.

The results suggest not only that lung cancer patients, as opposed to other chest unit patients, have a poor outlet for emotional discharge but also that lung cancer patients who are non-inhalers have the poorest outlet.

The previous conclusion that lung cancer patients are not a random sample of cigarette smokers can now be expanded to state that *there are significant personality differences between lung cancer inhalers and other chest unit patient inhalers, between lung cancer non-inhalers and other chest unit patient non-inhalers and between inhalers and non-inhalers with lung cancer.*

(ii) *Quantity smoked*

From Table 5 it can be seen that the differences between the lung cancer and the control patients in respect of both measures of outlet for emotional discharge are present at all levels of cigarette smoking as well as in those who had never smoked. Analyses of variance show the poorer outlet for emotional discharge in the lung cancer patients to be significant at the 0·001 and 0·01 levels for N and C.B.D. scores respectively. Thus the personality characteristic is present irrespective of cigarette smoking status.

Outlet for emotional discharge and exposure of bronchi to cigarette smoke

At the start of this paper mention was made of the possible importance of degree of exposure of lung tissue to cigarette smoke in the development of lung cancer. It is now proposed to examine both measures of outlet for emotional discharge in terms of degree of exposure of lung tissue to cigarette smoke. For

Table 5. *N scores and C.B.D. incidences in lung cancer and control patients according to cigarette smoking status*

	Mean N scores with standard deviations								C.B.D. incidences (percentage)			
	Never smoked		Cigarettes daily								Cigarettes daily		
			1–14		15–24		25+			Never smoked	1–14	15–24	25+
	N	S.D.	N	S.D.	N	S.D.	N	S.D.					
Lung cancer	2·0 (5)	1·3	3·6 (43)	3·8	3·5 (100)	3·5	3·8 (66)	3·4		20·0 (5)	26·2 (43)	34·7 (100)	22·7 (66)
Control	4·7 (17)	4·4	4·9 (61)	3·6	4·9 (81)	3·7	5·3 (36)	3·7		53·0 (17)	44·3 (61)	51·8 (81)	47·2 (36)

this purpose smokers have been arranged in descending order of exposure of their lungs to smoke (Table 6), following Hammond in assuming that the lungs of light or medium cigarette smokers who inhale are more exposed to cigarette smoke than those of heavy cigarette smokers who do not inhale.

It can be seen in lung cancer patients that there is a descending gradient in N scores with descending order of exposure of their lungs to cigarette smoke. In the number studied the descending gradient does not reach significance ($P > 0.09$) but the difference between the three more heavily and the two less heavily exposed is significant at the 0.025 level according to analysis of variance tests. No such gradient is seen for the non-cancer patients.

For the C.B.D. score the gradient is less apparent in the lung cancer patients mainly because of slight inversion in the two most heavily exposed groups (in the non-smokers the figure 20 % is accounted for by 1 out of 5), but even with this measure there is a suggestive difference, at the 0.025 level of significance, between the heavier and lighter exposure groups. Again non-cancer patients show no suggestion of such differences.

The lower exposure to cigarette smoke of lung cancer patients with low N scores is primarily due to less inhalation. This is illustrated by Table 7 which shows inhaling habits and smoking levels at each level of N score. According to these figures, the average level of cigarette consumption by lung cancer patients at each N level did not vary greatly, but in each of the three N score groups in the range 0–4, which corresponds with the lung cancer range and may be regarded as 'low', the percentage of inhalers is significantly below that for the non-cancer controls at the 0.001 level as shown by analysis of variance of the type referred to above. With higher N scores the differences are less marked and more variable and indeed show little overall difference between lung cancer (86.4 %) and controls (87.2 %). On the other hand, it can be seen that at almost every level of N score there are on the average more cigarettes smoked per day by the lung cancer patients than by the non-cancer patients, differences shown by analysis of variance to be significant at the 0.01 level.

Table 6. *Lung cancer and control patients in order of exposure to cigarette smoke and in relation to outlet for emotional discharge*

Exposure to cigarette smoke		Lung cancer		Control		C.B.D. (percentage) Lung cancer	Control
	Cigarettes daily	Mean N	S.D.	Mean N	S.D.		
Inhalers	25+	4.0 (50)	3.3	5.2 (33)	3.9	28.0 (50)	45.5 (33)
	1–24	3.8 (120)	3.7	4.9 (129)	3.5	35.9 (120)	44.6 (129)
Non-inhalers	25+	3.5 (16)	3.8	6.7 (3)	0.9	18.3 (16)	66.7 (3)
	1–24	2.2 (23)	2.9	5.2 (13)	3.9	4.3 (23)	61.5 (13)
Never smoked		2.0 (5)	1.3	4.7 (17)	4.4	20.0 (5)	53.0 (17)
All		3.6 (214)	3.4	5.0 (195)	3.7	28.9 (214)	46.9 (195)

(iii) *Psychosomatic history*

In a previous paper (Kissen & Eysenck, 1962) it was shown that in both lung cancer and control groups mean N scores were higher in those with a history of psychosomatic disorder than in those with no such history. The possible influence of such a history on inhaling habits is therefore examined here. For the purposes of this paper the term 'psychosomatic disorder' refers to one of the commonly accepted psychosomatic disorders such as have been listed by Kissen (1958, 1962) and by Sainsbury (1960).

Further subdivision of non-inhalers and inhalers in the psychosomatic and non-psychosomatic groups into age groups and according to quantity smoked would be impracticable because of small numbers in many of the subdivisions.

The incidence of a psychosomatic history (Table 8) is higher among inhalers than among non-inhalers both for lung cancer and control groups, but especially for the lung cancer group in which the figures reach statistical significance ($\chi^2 = 3.86$, $P < 0.05$).

However, among lung cancer patients, whatever the psychosomatic history, non-inhalers have a poorer outlet for emotional discharge compared with inhalers, as shown both in N scores and C.B.D. incidence (Table 9).

Among control patients, N scores and C.B.D. rates tend to be higher in those with a psychosomatic history whether or not they inhale but none of the differences is significant.

EXTRAVERSION

The findings here (Table 10) support the trend to extraversion among the lung cancer patients compared with the controls as previously reported by Kissen & Eysenck (1962) in a smaller series. However, as in the

Table 7. *Inhaling incidences and average daily cigarette consumption according to N scores in lung cancer and control patients*

N scores	Numbers		% inhalers		Average number of cigarettes daily			
					Lung cancer		Control	
	Lung cancer	Control	Lung cancer	Control	Av. no.	S.D.	Av. no.	S.D.
0	60	29	71·7	89·7	19·6	10·5	17·9	8·4
1–2	52	33	82·7	97·0	23·8	11·8	18·8	9·2
3–4	31	30	87·1	96·7	22·6	11·8	19·6	11·0
5–6	27	32	85·2	78·1	24·3	11·8	17·2	9·7
7–8	18	23	94·4	91·3	19·0	6·3	18·7	5·7
9–10	13	17	69·2	100·0	19·7	10·0	19·8	8·0
11–12	8	14	100·0	85·7	22·1	8·0	17·6	8·3
All cigarette smokers	209	178	81·3	91·0	21·5	11·5	18·5	9·0

Table 8. *Incidence of psychosomatic history according to inhaling habits in lung cancer and control patients*

Lung cancer				Control			
Non-inhaler		Inhaler		Non-inhaler		Inhaler	
No.	%	No.	%	No.	%	No.	%
10	25·7	75	44·1	7	43·8	87	56·2
(39)		(170)		(16)		(162)	

Table 9. *Outlet for emotional discharge in lung cancer and control inhalers and non-inhalers according to psychosomatic history*

	N scores							
	Non-psychosomatic				Psychosomatic			
	Non-inhaler		Inhaler		Non-inhaler		Inhaler	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Lung cancer	2·8 (29)	3·4	3·5 (95)	3·4	2·4 (10)	3·2	4·2 (75)	3·6
Control	5·3 (9)	4·5	4·6 (75)	3·6	5·7 (7)	2·8	5·3 (87)	3·8

	C.B.D. incidence							
	Non-psychosomatic				Psychosomatic			
	Non-inhaler		Inhaler		Non-inhaler		Inhaler	
	No.	%	No.	%	No.	%	No.	%
Lung cancer	1 (29)	3·5	24 (95)	25·3	3 (10)	30·0	33 (75)	44·0
Control	5 (9)	55·6	25 (75)	33·3	5 (7)	71·4	48 (87)	55·2

Table 10. *Extraversion scores in lung cancer and control patients; comparison between inhalers and non-inhalers according to amount smoked*

	Lung cancer				Control			
	Non-inhaler		Inhaler		Non-inhaler		Inhaler	
Cigarettes per day	Mean E	S.D.	Mean E	S.D.	Mean E	S.D.	Mean E	S.D.
1–24	7·9 (23)	2·9	7·2 (120)	2·6	7·5 (13)	2·9	6·7 (129)	3·1
25+	8·0 (16)	2·2	7·1 (50)	2·9	6·7 (3)	2·4	7·4 (33)	3·2
All cigarette smokers	8·0 (39)	2·6	7·2 (170)	2·7	7·4 (16)	2·7	6·9 (162)	3·1

previous series, none of the differences in this series reaches statistical significance.

Comparison between non-inhalers and inhalers (Table 10) shows the non-inhalers to be more extraverted than inhalers both in the lung cancer and control groups, but here too none of the differences reaches statistical significance. Although not shown in the tables such trends are in fact present in three age group subdivisions of lung cancer patients though not of controls where the numbers become very small.

When quantity smoked is considered the heavier smoking control group tends to be

more extraverted than the lighter smoking control group, though the difference is not statistically significant (one may exclude the non-inhalers here because of the small numbers). This is in accord with Eysenck's (Eysenck *et al.* 1960; Eysenck, 1963) findings for smokers. It is interesting to note that no such trends are apparent in the lung cancer group where the mean *E* score in the light and heavy smokers groups are almost identical.

When extraversion scores are arranged, as was done with *N* scores, in order of exposure to cigarette smoke (Table 11) there is an ascending gradient in scores from the most heavily exposed group downwards in the lung cancer patients, but not in the controls. This gradient does not reach statistical significance nor does the difference between heavier and lighter exposed groups.

When psychosomatic history is taken into account (Table 12) differences between non-inhalers and inhalers with lung cancer are for the most part still apparent. Differences between lung cancer and controls are only present in the psychosomatic group though not reaching statistical significance. Therefore, the apparent extraversion of lung cancer patients as compared with the controls is seen here only among those with a psychosomatic history. An explanation for this may be that

Table 11. *Extraversion scores in lung cancer and control patients according to exposure to cigarette smoke*

Exposure to cigarette smoke		Cigarettes daily	E scores			
			Lung cancer		Control	
			Mean E	S.D.	Mean E	S.D.
Inhalers		25+	7·1 (50)	2·9	7·4 (33)	3·1
		1–24	7·2 (120)	2·6	6·7 (129)	3·2
Non-inhalers		25+	8·0 (16)	2·2	6·7 (3)	2·4
		1–24	7·9 (23)	2·9	7·5 (13)	2·9
Never smoked			8·9 (5)	2·9	7·9 (17)	3·0
All			7·5 (214)	2·8	7·0 (195)	3·0

Table 12. *Extraversion scores in lung cancer and control patients; comparison between inhalers and non-inhalers according to psychosomatic history*

	Non-psychosomatic				Psychosomatic			
	Non-inhaler		Inhaler		Non-inhaler		Inhaler	
	Mean E	S.D.	Mean E	S.D.	Mean E	S.D.	Mean E	S.D.
Lung cancer	7·9 (29)	2·4	7·2 (95)	2·8	8·2 (10)	2·9	7·2 (75)	2·3
Control	7·9 (9)	2·1	7·1 (75)	3·1	6·7 (7)	3·4	6·7 (87)	3·2

the psychosomatic controls tend towards introversion as Sainsbury (1960), Kissen & Eysenck (1962) and Eysenck (1963) found, and relative to this the extraversion of the cancer patient becomes exaggerated. Among lung cancer patients, non-inhalers appear to be more extraverted than inhalers irrespective of psychosomatic history. Investigation of larger numbers, however, is needed to show such trends more definitely.

CONCEALMENT

The difference between non-inhalers and inhalers in lung cancer patients in respect of conscious concealment tendencies (Table 13) is not significant and there are no differences between non-inhalers and inhalers among the controls. The greater proneness to concealment among the lung cancer patients is present in both non-inhalers and inhalers.

There are no other suggestive differences between inhalers and non-inhalers in relation to quantity smoked or psychosomatic history, but further subdivision in these categories makes the numbers in the non-inhalers too small for effective comparison.

DISCUSSION

The evidence given in this paper suggests that both cigarette smoking and a characteristic personality appear to be involved in the development of lung cancer. If one accepts the view that lung cancer is of multiple aetiology and that among factors associated with its development are an exogenous one of exposure to cigarette smoke and an endogenous one of personality, it would appear that *the poorer the outlet for emotional discharge the less the exposure to cigarette smoke required to induce lung cancer*. Such an observation, based on the findings of this study, is consistent with some of the anomalous epidemiological findings regarding inhalation and may explain in part why some light smokers develop lung cancer while others who smoke more do not.

It should be noted that N scores and C.B.D. percentages are *averages* and that the lung cancer group includes some with high N scores and some with C.B.D. and conversely the control group includes some with low N scores and no C.B.D. These measures therefore are not invariably accurate indicators of *individual* susceptibility.

It may be argued that a control group of chest unit patients is not representative of the so-called 'general public'. As has been pointed out above, this control group was chosen to avoid bias as far as possible by ensuring like environmental conditions for the two groups at the time the psychological responses were being elicited. Kissen (1964c, d) has drawn attention to the possible influence of different environmental settings in neuroticism scores. Consequently, to supplement this study, N scores were measured in the same way as previously in a second control group of non-cancer male patients from non-chest medical and surgical wards in the same hospitals. Because patients convalescing from major surgery were found to have high N scores (Kissen, 1964d), post-operative

Table 13. *Concealment incidences in lung cancer and control patients;*
comparison between non-inhalers and inhalers

	Non-inhalers		Inhalers	
	Concealers	%	Concealers	%
Lung cancer	20 (39)	51·3	99 (170)	58·2
Controls	7 (16)	43·8	71 (162)	43·8

patients were excluded. The numbers in this further control group were insufficient to permit consideration of inhaling habits in relation to personality. The findings, nevertheless, are striking and are summarized and compared with the other groups as shown in Table 14.

Assuming that men aged 25 and over suffering respectively from lung cancer and from non-cancer non-chest diseases can be taken as representing male lung cancer deaths and men generally in Scotland, the lung cancer mortality rates per 100,000 men aged 25 and over, by levels of neuroticism scores, in Scotland in 1961 are 308, 106, 56 (average 145) for N score ranges 0–2, 3–8 and 9+ respectively. Thus lung cancer mortality rates of those with a poor outlet for emotional discharge as measured by low N scores is more than five times greater than those with a good outlet and nearly three times greater than those with an intermediate outlet.

Similar calculations of lung cancer mortality rates by levels of extraversion scores show no marked trends.

These studies have so far been concerned with lung cancer. Whether or not the personality findings may be common to other cancers cannot be answered here. Coppen & Metcalfe (1963), using the full version of the M.P.I., studied women with cancer in a general hospital. They used two control groups, a group of hospital controls without tumour and a general population control group obtained from a representative sample of the London area. The two control groups had similar mean E scores but the cancer group had a significantly higher E score (25·38 compared with 21·11 and 21·32). The cancer group and general population controls had similar mean N scores of 23·53 and 23·65, whereas the hospital controls had a mean N score of 25·79, a difference, however, that is not statistically significant. They infer that if the difference in E scores were the result of illness or of the stay in hospital the N scores should have been similarly affected. This, however, is not necessarily so. There is evidence to suggest that the emotional accompaniment of entering hospital might cause a rise in mean N scores (Kissen, 1964d). Indeed, their non-cancer patients showed this. The failure of the cancer patients to respond in this way is consistent with the poorer ability of cancer patients to discharge emotion. It may also be that the mean N score of their cancer patients would have been much lower than the controls if obtained under normal home conditions prior to having to enter hospital. It should be added that even if N scores are affected in this way, the estimates given above concerning lung cancer mortality and outlet for emotional discharge would still be valid, the respective N scores for cancer and control patients representing the respective responses of these groups in a particular circumstance.

Hagnell (1961) found extraversion to be a significant feature of women with cancer, but pointed out that this feature was much less marked in males with cancer and this is perhaps consistent with the extraversion findings reported in this paper.

A number of questions may now be posed. Why do non-inhalers have the poorest outlet for emotional discharge among the cigarette smoking lung cancer patients? Is it that non-inhalation represents a denial of outlet for emotional tension that inhalation is sometimes thought to provide? If this is so, one

Table 14. *N scores*

(Men aged 25+ approximately age matched.)

Patient group	0–2	3–8	9+	Total	No. in sample	χ^2	P
Lung cancer	55	35	10	100	214	—	—
Other chest unit	36	46	18	100	195	15·4 ($n = 2$)	< 0·001
Non-cancer non-chest	26	48	26	100	91	26·2 ($n = 2$)	< 0·001

would expect lung cancer patients who never smoked and therefore had always denied themselves this potential outlet, to have the poorest emotional outlet. The low N score of 2·0 is consistent with this and the occurrence of only one patient with a C.B.D. history could also be consistent.

Does the giving up of smoking by persons who later become lung cancer patients also represent denial of an emotional outlet that had previously been utilized? That this could be the case is suggested by figures for lung cancer ex-cigarette smokers, whose mean N score of 3·1 is lower than that of continuing smokers −3·7. It is worth noting, however, that 48 % of the lung cancer ex-cigarette smokers had been non-inhalers, in contrast to 14 % of current smokers.

Finally, if, as is suggested above, non-smoking in lung cancer patients represents denial of an emotional outlet that cigarette smoking provides, should it be expected that among cigarette smokers the poorer the outlet the less the cigarette consumption? Or, on the contrary, might it not be that the more effective the outlet the less the need for a tension reducer, and therefore, the less the cigarette consumption? If, as is generally believed, cigarette smoking is used as a tension reducer is it not possible that it may be used by some with a poor emotional outlet in an unconscious endeavour to find an outlet as well as by some with a high emotional outlet in a deliberate endeavour to ease tension?

Cigarette smoking motivation is complex and, as yet, most imperfectly understood. The available evidence suggests an interplay of many factors. Until much more is known about smoking motivation the very pertinent questions posed above cannot be properly answered.

SUMMARY

This paper gives an account of cigarette smoking and inhaling habits of male lung cancer patients and non-cancer controls in relation to a number of personality features.

The lung cancer group contains more smokers and smokes more cigarettes per head than the non-cancer group.

Typically lung cancer patients have a poor outlet for emotional discharge. This feature is present irrespective of quantity smoked but is more marked among non-inhalers. When this personality feature is measured in terms of degree of exposure of lungs to cigarette smoke (which takes account both of quantity smoked and inhaling habits) it is found that the poorer the outlet for emotional discharge the less the cigarette smoke required to induce lung cancer. Lung cancer mortality rates of those with a poor outlet for emotional discharge may be five times greater than those with a good outlet.

Extraversion and concealment, two other personality features with which lung cancer may be associated, showed no suggestive relationship with exposure to cigarette smoke.

The significance of the finding is discussed in relation to possible cigarette smoking motivation factors.

It is suggested that the findings may explain, at least in part, some of the apparently anomalous epidemiological findings regarding inhalation and also why some non-smokers and light smokers can develop lung cancer while others who smoke more do not.

REFERENCES

BRESLOW, L., HOAGLIN, L., RASMUSSEN, G. & ABRAMS, K. (1954). Occupations and cigarette smoking as factors in lung cancer. *Amer. J. Publ. Hlth,* **44**, 171–81.

British Medical Journal (1962). Any Questions? **2**, 1270.

COPPEN, A. J. & METCALFE, M. (1963). Cancer and extraversion. *Brit. Med. J.* no. 5348, 18–19.

DOLL, R. & HILL, A. B. (1952). A study of the aetiology of carcinoma of the lung. *Brit. Med. J.* **2**, 1271–86.

EYSENCK, H. J. (1959). *Manual of the Maudsley Personality Inventory.* University of London Press.

EYSENCK, H. J. (1963). Smoking, personality and psychosomatic disorders. *J. Psychosom. Res.* **7**, 107–30.

EYSENCK, H. J., TARRANT, M., WOOLF, M. & ENGLAND, L. (1960). Smoking and personality. *Brit. Med. J.* **1**, 1456–60.

HAGNELL, O. (1961). Epidemiologi och aldrande. *Svenska Läkartidn.* **58**, 492.

HAMMOND, E. C. (1959). Inhalation in relation to type and amount of smoking. *J. Amer. Statist. Ass.* **54**, 35–51.

HAMMOND, E. C. (1961). Prospective studies on smoking in relation to death rates. *Bulletin de L'Institut International de Statistique*, 33rd Session. Paris.

KISSEN, D. M. (1958). *Emotional Factors in Pulmonary Tuberculosis*. London: Tavistock Publications.

KISSEN, D. M. (1962). Relationship between primary lung cancer and peptic ulcer in males. *Psychosom. Med.* **24**, no. 2, 132–47.

KISSEN, D. M. (1963a). Personality characteristics in males conducive to lung cancer. *Brit. J. Med. Psychol.* **36**, 27.

KISSEN, D. M. (1963b). Aspects of personality of men with lung cancer. *Acta Psychother.* **11**, 200–10.

KISSEN, D. M. (1964a). Lung cancer, inhalation and personality. In *Aspects of Neoplastic Disease*. London: Pitman.

KISSEN, D. M. (1964b). Letter to *The Lancet*, 25 Jan. pp. 216–17.

KISSEN, D. M. (1964c). In *Proceedings of 1963 Conference of Society for Psychosomatic Research on Measurement in Psychosomatic Research*. London: Pergamon. (In the Press.)

KISSEN, D. M. (1964d). The influence of some environmental factors on personality inventory scores in psychosomatic research. *J. Psychosom. Res.* (In the Press.)

KISSEN, D. M. & EYSENCK, H. J. (1962). Personality in male lung cancer patients. *J. Psychosom. Res.* **6**, 123–37.

LICKINT, F. (1953). *Antiologic und Prophylaxe des Lungenkrebses*. Dresden: Steinkopff.

LOMBARD, H. L. & SNEGIREFF, L. S. (1959). Epidemiological Study of Lung Cancer. *Cancer*, **12**, no. 2, 406–13.

ROYAL COLLEGE OF PHYSICIANS (1962). *Report on Smoking and Health*. London: Pitman.

SAINSBURY, P. (1960). Psychosomatic disorders and neurosis in out-patients attending a general hospital. *J. Psychosom. Res.* **4**, 261–73.

SCHWARZ, D., FLAMANT, R., LELLONCH, J. & DENOIX, P. F. (1961). Results of a French survey on the role of tobacco, particularly inhalation, in different cancer sites. *J. Nat. Cancer Inst.* **26**, 1085–108.

SNEDECOR, G. W. (1956). *Statistical Methods* (fifth edition). Iowa, U.S.A.: Iowa State University Press.

SPICER, C. C. (1963). Private communication.

TODD, G. F. (1962). *Statistics of Smoking in the United Kingdom* (3rd edition). London: Tobacco Research Council.

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE (1964). Report of Surgeon General's Committee on 'Smoking and Health'.

On the rationale of psychodynamic argumentation

By NEIL M. CHESHIRE*

It would not be denied that, in the doctrinal disputes which continue to arise between psychologists who hold on the one hand that psychodynamic theories of behaviour are significant and constructive, and those who preach, on the other, a sterner creed of conditioning and experimentalism, the former have often been accused of intellectually disreputable romancing (and more recently of being 'actively pernicious'—Prof. Eysenck talking), while the latter have typically prided themselves on being 'scientific'. It is also true that the latter group, when challenged by the uncommited inquirer to 'give a reason for the faith that is within them', have been able to impress, and perhaps overawe, him by chanting in well-drilled unison, 'the hypothetico-deductive method'. Whereas the psychodynamists have been somewhat at a loss in such a situation, not having a similar tripping catch-phrase on the tip of their tongue, and may therefore, in the eyes of some, have appeared to fail their *viva*; while the fact that their views have commanded wide respect among such children of fantasy and emotion as the world's artists, novelists and playwrights is turned into a debating point *against* them by their allegedly more objective detractors.

Recently, however, some attention has been given to examining the logical framework of psychodynamic and allied argumentation (Farrell, 1961, 1963; Bromley, 1963), and I want here to make some further suggestions that may contribute to this end: first, by taking a look at a well-known passage in which the rationality of such arguments is questioned (even denied); secondly, by pointing to a highly respected and constructive rational procedure that has features re-

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markably similar to just those aspects of psychodynamic discourse that are mistakenly alleged to undermine its rationality; and thirdly, by offering a sketch of the implied logical structure from which psychodynamic speculation derives such rationality as it has. But before embarking on the first point, a preliminary observation.

It will be noticed that I am not proposing to show that psychodynamic enterprises can be logically respectable by virtue of being disguisedly *scientific* in the limited hypothetico-deductive sense: nor indeed that they necessarily can be regarded as 'scientific' in *any* sense. This is because, as Farrell has pointed out, studies and activities do not have to be scientific (still less, strictly hypothetico-deductive) in order to be rational. The class of scientific enterprises is not co-extensive with that of rational ones: the latter is larger than the former. It is true, of course, that hypothetico-deductive procedures can provide an especially rigorous *check* on the truth of particular theories, etc., *if and when* (a) the structure of the constituent hypotheses is such that it is clear precisely what consequences are to be deduced from them for particular situations, and (b) the postulated variables are such that (experimental) conditions which isolate their effects can be set up, or can be shown to have been fulfilled. But when the theoretical situation is not like this, as when the terms in the 'hypotheses' are wishes, fears, conflicts and motives (and probably 'unconscious' ones at that), it is inappropriate to expect the same sort of evidence to be offered in support of such theories, or a particular application of them, as might be offered in a context where variables are more precisely observable and even quantifiable.

Some of the negative implications of this

have by now, of course, become platitudes—e.g. you cannot easily experiment with human experience: you cannot obviously measure states of mind—and they have led to the nihilistic excesses of a minority of behaviourists, who, rightly insisting (from *their* methodological point of view) on a *particular sort* of 'evidence', have thrown the baby out with the bath-water and then been embarrassed by the need to conceal the baby-clothes that were left behind. But the positive alternative, the question of what you *can* do *instead* in order to assess the validity of psychodynamic theories and use them coherently, is by no means so well understood. Indeed there are those who wish to persuade us that there is *no* intellectually respectable alternative open to the psychodynamist; that he is bound to ape the tactics of the experimentalist, only to be found either logically or empirically wanting because his induced law-like generalizations are not universal and/or specific enough to produce validly the sorts of inference that he is supposed to want to make from them—such specificity and universality typically being conferred on generalizations about *other* sorts of data precisely (and perhaps only) by hypothetico-deductive refinement.

But the mistake here is the assumption that the psychodynamist, whose basic generalizations are admittedly loose, necessarily relies on such patterns of inference as are appropriate only to more rigorous premises, and that he is therefore doomed to fallacy. Let us look at 'a good rousing summary and elaboration of these misconceptions' as presented by Prof. Eysenck (*Sense and Nonsense* ..., pp. 227 ff.).

I

Eysenck is here concerned to claim that to 'argue back' from observed behaviour (and specifically from the data of projective test records) to 'the cause or factors which are responsible for our action'—as the psychodynamist undoubtedly wants to do—is an exercise 'based on a logical fallacy': and the accusation of logical fallacy is repeated on each of the three pages that contain his argument.

He contends that such arguing back *necessarily* involves the illicit conversion of the major premiss of a simple syllogism, and he gives two examples of a kind of psychodynamic 'arguing back' which *as he represents it* certainly exhibits such a fallacy. But the question at once arises: is this the *sort* of 'arguing back' on which the psychodynamist necessarily depends? And the answer to this is, 'No'. False conversion is *a* sort of arguing back, but it is not the *only* sort. Eysenck has in fact misrepresented the logical model to which the psychodynamist appeals in his arguing back: he is *not* reduced merely to pressing into service isolated syllogisms for which his major premisses are insufficiently rigorous.

Specifically, Eysenck complains that 'all the projective techniques' and, by implication, all psychodynamic accounts of behaviour, take the fallacious form of his analogy about 'sporting young men' buying Jaguar sports cars. The paradigm syllogism attributed to the psychodynamist by this analogy is:

1. Sporting young men buy Jaguar sports cars.
2. This man has bought a Jaguar sports car.
3. Therefore this man is a sporting young man.

This is clearly invalid, and can be rescued from invalidity only by tightening up the major premiss to read 'Only sporting young men buy Jaguar sports cars', which runs the risk of resting the argument on a false negative existential generalization of the form: 'There is no man who is a Jaguar sports car buyer and not a sporting young man.' Now, not even the most zealous and committed psychodynamist would claim that the generalizations of his theory have yet been refined to this degree of precision and exclusiveness: and it may be that such refinement (of loose propositions of the form 'A's tend to be B's' into parallel ones of the form 'Alphas and only alphas are betas') can be achieved only by hypothetico-deductive investigation, which is likely to be, for reasons outlined above,

systematically inapplicable to the sort of data and concepts involved. But, granted that the psychodynamist's 'laws' are of the looser form, and destined to remain so for some time at least, does it follow that their use in 'arguing back' operations *necessarily* involves a 'logical fallacy'? The answer here is again, 'No': because they do not have to be used as the major premises of a single unsupported syllogism that commits the fallacy of the 'undistributed middle'. This is not the only way in which they can be used, and it certainly is not the way in which they typically function in psychodynamic interpretations or 'explanations' of behaviour. In short, Eysenck's imputations of fallacy are valid if, and only if, he has accurately represented the logical scheme on which such formulations depend. To the extent to which he has not done this—because he has *inter alia* omitted (much less considered the logical role of) the essential criteria of 'coherence' or 'goodness of fit' (see Farrell, 1963)—to that extent his onslaught achieves no more than a hollow victory over a particularly slender straw man.

A further small point, which is perhaps symptomatic of his indifference to the accuracy of the logical parallel between the Jaguar analogy and the psychodynamist's, or projective technician's, position, is that he can write (p. 228): 'In other words, buying a Jaguar sports car is regarded as a kind of projection test....'. But if there is to be the remotest parallelism here at all, then the situation that corresponds to the projective test is not buying the Jaguar but rather the presentation, or existence, of a range of different makes and models from which to choose. The *selection* of a Jaguar from such a range corresponds, if anything, to the projective test *record* or protocol, which consists of the perceptual and interpretive *selections* made by the patient from the range of alternatives open to *him*. But even in this revision the analogy would still be distinctly precarious. Because what is our car-buyer supposed to have 'projected', in this case, on to (or into, as Klein would have it) the stimulus-

material; i.e. on to either the car of his choice or the range of possible cars? He has in no sense perceived, re-structured, re-organized it in his own way: what he has done is to associate himself with some properties of it rather than with others. This may be partly what Klein means by 'projective identification', but on the face of it the whole business looks more *intro*-jective than projective, and one might perhaps compare Ferenczi's (1909) analysis, in terms of introjection, of Jung's word-association technique.

Now, in order to show that there can be 'arguing back' which is based on premises looser than the sort of universal exclusive generalization that Eysenck stipulates, and which is, nevertheless, not necessarily fallacious, I propose to draw attention to a semantic procedure that is indubitably rational but which (*a*) is non-scientific, (*b*) employs premises of the 'loose' form that we are concerned with, and yet (*c*) is capable of producing 'conclusions' or inferred judgements that can be regarded with considerable (sometimes even complete) confidence as 'true' or 'correct'. I refer to the process of translation from one language to another: more especially, for the sake of the comparison, to translation from a dead language. For although, as I have noted above, Farrell has pointed out other examples of enterprises which are conducive to rational explanation or understanding but which are not 'scientific', and Bromley (1963) has elaborated a suggestion of Toulmin's (1958) in trying to formulate the implied logical scheme of a certain kind of jurisprudential argument, yet there are specific features of the translation situation that resemble rather closely just those aspects of psychodynamic propositions and logical tactics which are sometimes supposed to undermine the validity of the arguments in which they figure.

II

The rendering into English of a passage of, for example, classical Latin can be treated as an empirical claim of the form: 'When Tacitus

(or Virgil or whoever) wrote such-and-such he meant (or, intended to convey the idea) so-and-so.' It is in fact an instance of 'arguing back' from a presented datum (in this case, the Latin text) to the ideas and intentions that gave rise to it (in this case, what Tacitus 'wanted to say'). But although it is thus a species of empirical explanation, connecting present observations with postulated antecedent determinants, there is presumably no question of strictly deriving particular consequences from the 'hypothesis' that, for example, by *arcana imperii* Tacitus meant 'secrets of government' and then running an empirical study to see whether in the stipulated conditions, such consequences are observed to occur. We cannot control conditions retrospectively, any more than we can wind back a patient's psychopathological development to see what would have happened if . . . ; and any way, what sort of conditions would we want to control (in the case of the translation) and what would the 'consequences' look like? For there are any number of consequences which, as regards the meaning of the words, could be so 'derived' with equal cogency, as we shall see below: and if we look for watertight empirical generalizations about habits of word-usage we shall find that it is the exception for a word to occur only in such uniformly predictable circumstances that its meaning can always be fixed by reference to them.

It may be thought that the validation of particular propositions about the past, the logic of which has presented some problems to the verificationists, lies systematically outside the scope of hypothetico-deductive method and must therefore be relegated from the plane of science to that of mere historical speculation, with the result that all forms of empirical 'arguing back' would have to be regarded as non-scientific. Even if this were true, we should still rightly continue to ask whether a given judgement about the past was 'rational', or (which is the same thing) what grounds or evidence there were for accepting it. But in fact, of course, there are both (*a*) propositions about past events that can be directly checked by the hypothetico-deductive method, if such events occurs in a relatively isolated, continuing system whose structure is so well understood that predicted results, or effects, of the postulated events can be rigorously deduced for specific conditions which can still arise or be produced at some future time, even though the intervening conditions have not been experimentally controlled: and also (*b*) propositions about past events which are 'scientific' not by virtue of having been hypothetico-deductively checked in themselves, but because (1) the events concerned were members of a class of events which continued to occur, and (2) the laws governing that class have been established by hypothetico-deductive investigation of such different members, and (3) the propositions about the past members are deducible from the established generalizations covering all members of the class.

So it is not just that judgements about the past, such as in our translation, have a special dispensation and are allowed to be non-scientific because they are inaccessible to hypothetico-deductive method. Is it the case then, that the rationality of translation-judgements (such as 'by such-and-such Tacitus meant so-and-so') consists in their being logically parallel to (*b*) above, because the meaning behind a particular use of a word is deducible from a rigorous generalization about *all* instances of that word? But words rarely have just a single, universal meaning. Are they inferred, that is to say, from premisses as rigorous as 'nobody but a sporting young man buys a Jaguar sports car', which Eysenck apparently thinks essential to rational 'arguing back'? Indeed they are not. It follows then—assuming we allow that translating is, or can be, a rational enterprise—that there can be forms of arguing back which are both intellectually respectable and neither immediately hypothetico-deductive nor rigorously inferable from an established 'covering-law' generalization. But in what else can their rationality consist? Let us refer back to the example of translation for a lead.

The generalizations which a translator uses, in deriving his conclusion about what a passage of Latin means, are not of the form: 'every instance of the word *mensa* reflects the idea of "table".' For although a minority of technical terms may possibly admit of an approximation to this degree of rigidity, it is obvious that most words can convey more than one idea; it may be the case that *curculio* always means 'boll-weevil', but it is not even true that *et* always means 'and'. For the most part, then, the translator *cannot* rely on arguments of the form:

(1) Instances of the word 'X' always convey idea 'Y'.
(2) This is an instance of word 'X'.
(3) Therefore this means 'Y'.

He has to be content with generalizations like, 'X usually means Y, but sometimes means Z', or like, 'X can mean anything to do with Y, such as Ya, Yb, Yc, . . ., Yn': or even, looser still, like, 'X sometimes means Y, sometimes Z, sometimes P etc., with equal frequency'. So that, if the translator's implied scheme of argumentation were restricted to what Eysenck attributes to the psychodynamist, he would obviously never be able to arrive rationally at conclusions such as, 'What Tacitus is saying here is so-and-so'. But, since we *do* regard translating from Latin as a rational enterprise, the translator must have other logical cards up his sleeve: and if the translator, why not the psychodynamist also? Clearly, the nature of such supplementary cards is worth investigating.

But before doing so, it will be instructive to note some further respects in which the looseness or flexibility of the translator's premisses resembles that of the empirical generalizations with which the psychodynamist has to work. For the translator has to make do not only (a) with propositions which are non-specific— so that X may *tend* to mean such-and-such but may sometimes mean this, that, or the other more-or-less related idea instead; but even (b), in some cases, with propositions that are almost contradictory in the disjunctions

they express. Thus the premisses may take the form: 'The word X can mean either Y or the reverse of Y': where 'the reverse' covers the idea of different sorts of opposition.

Examples of (a) are, of course, two-a-penny: but examples of (b) would be (1) *subire*, which can either mean 'to rise up' or 'to sink down' and (2) *caecus*, which can mean both (actively) 'unable to see' and (passively) 'unable to be seen'. Moreover, this 'active' versus 'passive' variation on a basic theme reflects a systematic principle underlying the development of transferred meanings out of root meanings. As regards (a), the psychodynamic generalization will often have to take the form: 'Such behaviour tends to derive from motive x, but can have different determinants.' Compare Farrell's example (1961) of 'the boy D', where the parallel proposition would run: 'In such a situation aggressive anti-social behaviour tends to reflect the need to test out a new environment, but it may be produced by a brain-tumour among other things.' In a case like this, a theory that appeals to the tendency without explicitly ruling out the alternatives (which usually cannot be done retrospectively) is apt to be dismissed as arbitrarily selective. And as regards (b), it is the precisely analogous versatility of some psychodynamic hypotheses (when they involve such concepts as repression, over-compensation and reaction-formation) that leads to the grievance that psychodynamists can account for anything in retrospect and predict nothing in particular. For a psychodynamic theory may very well postulate that a given emotional conflict may issue in either an excess or a lack of a certain sort of behaviour: or in retrospect, that a given sort of behaviour may result from either an excess or a lack of a certain crucial sort of experience. Examples might be, of the latter, the linking of attention-seeking behaviour with either overprotection or emotional deprivation; and, of the former, the accounting for both anti-social aggressiveness and undue passivity by reference to an alleged conflict over authority-relations. This gives some

people the feeling that if both the presence and the absence of the behaviour (or experience) concerned will serve to support the psycho-dynamic 'explanation', then there are no observations that could conceivably count against it, no particular truth-conditions can be specified and the alleged explanation therefore becomes vacuous. How is it then that the translator, apparently forced to rely on similar sorts of material, manages to escape similar charges of arbitrary selectiveness or vacuity?

Suppose a pupil mistakenly translates the Latin *subit* as 'rises up' and his teacher corrects him, pointing out that *subire* can also mean 'sink down': the pupil protests in exasperation, 'Well, if it can mean opposite things, then you never know where you are with the word, truth-conditions for its meaning cannot be stipulated and a claim about what it means in a particular instance therefore becomes vacuous'. The teacher will answer this, of course, by showing that when it is taken in this particular context to mean 'sink down' then the sentence concerned fits in better with what is being said before and after it. But this metaphor of 'fitting in better', 'goodness of fit', 'coherence'—or whatever one chooses to call it—demands further analysis. For there is more than one point of view from which a thing may fit in, or fail to fit in, with other associated things: a book may fit in with others on the shelf perfectly as regards size and colour but be quite out of place with respect to subject or alphabetical order of authors. A question arises, then, about what *sort* of coherence is assumed to be relevant to the particular situation in hand, and on what logical structures such an assumption is based.

Now in the case of the *subire* translation, this coherence is not to be identified with *a priori* deductiveness. That is to say, the teacher is not claiming that if you suppose that *subit* means at this point 'sinks down' then what comes in the next few sentences could have been rigorously deduced: because clearly there are many things the author might

go on to say, *any* of which would be coherent and thus lend weight to the suggestion that *subit* here means 'sink down'. Imagine, for example, that the subject of *subit* is *sol*—the sun: then the teacher's argument might be thought to be something like: 'Since this is a vaguely pastoral/sociological bit of Virgil we are dealing with, then if he is talking about the sun setting, rather than rising, he is *likely* to go on to mention shadows lengthening, birds going to sleep, farmers coming home, candles being lit, and that *sort of thing*.' It is important that subsequent references to *anything* of this *sort* will do for the teacher's purpose. This can be seen to resemble closely the psychodynamic situation in which any of various different sorts of behaviour may be said to 'confirm' the existence of a postulated motive, conflict, etc. In the case of the translation, and also, I suggest, in the psychodynamic case, the scheme of the argument is not so much, 'If and only if he means *x* he will go on to say precisely *p, q, r* . . . and, lo and behold, he does': but rather, 'he is *likely* to have said *p, q, r unless* he had meant *x*'. This is partly because what would count as the 'consequences' of the 'hypothesis' are in this case part of the presented datum. So that, faced with a word of equivocal significance, one does not in fact (as indeed Newton in a different context claimed not to do) frame hypotheses. What one *does* say to oneself (which seems to me importantly different) is, 'Let's see what he goes on to say': and in the light of that one decides what he 'must have' meant by the problematical word. A species has to be resorted to *par excellence*, of course, in 'unseen' translation, when one simply does not know the meaning of some word at all and has to 'get it from the context'. But the fact that one has to get at it by a form of 'arguing back' does not make the whole business of unseen translation necessarily irrational or logically fallacious: although a Mods. don might think a particular pupil's effort 'irrational'. Which, however, only goes to show that there *are* efforts which *would be*

regarded as 'rational': or at least that there is a sense in which *some* such efforts *could* in principle be called rational.

However, the linguistic analogy breaks down when it comes to the specificity with which areas of unlikelihood can be adumbrated, and to assessing the confirmatory weight to be attached to subsidiary observations. That is, at least partly, because the background generalizations of a dead language are better plotted, in spite of all their Janus-like flexibility and versatility, than are the parallel propositions in psychodynamics: and because the data which have to be accounted for (i.e. the text to be translated) are much more complete, more closely inter-related and more minutely structured than the selected observations of a patient's behaviour with which the psychodynamist has to work. And yet if we were to consider how the high-level scholar functions when confronted with a corrupt and incomplete text which he has both to edit and to translate—that is to say, when he is asked to account for data which not only represent a mere selection from a continuous range but also contain some unspecified false observations—many points of affinity would emerge. For this sort of thing has to be done extensively, for instance, when the archaeologist calls upon him to reconstruct and interpret some damaged inscription that has been discovered on a stone in the middle of a desert; quite apart from the more minute 'textual criticism' of manuscripts. In such cases we should discover, I suspect, even closer resemblances to psychodynamic argumentation. I do not propose to go into this in detail here, because the classical analogy is already getting a bit tired: but I cannot resist giving one example. Mr B. A. Farrell drew my attention to the relevance of the relatively recent decipherment of the Minoan Linear Script 'B' by the late Michael Ventris. For reasons that will become apparent below (esp. pp. 224–5), I was delighted to find Chadwick in his account of the achievement (1960) saying, of the internal coherence that resulted from applying some of Ventris's ideas to the 'tripod' tablet found at Pylos, 'the odds against getting this astonishing agreement purely by accident are astronomical...'. So, before abandoning the analogy finally, let me press it just once more to make a last point about the possibility of having different sorts, or parameters, of coherence to appeal to even in the limited sphere of dead-language translation.

We have looked at an example where a guide to establishing coherence can be derived from the assumption that a descriptive passage is likely to refer to events temporally associated. This may be thought to have something in common with the principle of parsimony, in that a passage is treated as more likely to contain a few general themes than many separate ones: so also perhaps, in the case of a patient's psychopathology. But there will also be cases where appeal is made, not so much to the content of what is being said, as to the purpose, or motive, for which it is being said. Consider the case of a speech in which Cicero is defending a dubious gang-leader. We come upon a phrase containing a word that can mean, for example, 'clever' in either a laudatory or a pejorative sense, so that it could be rendered on the one hand, perhaps, 'intelligent' or, on the other, 'artful' or 'scheming'. The choice between these alternatives will be guided not by considerations about the speech hanging together internally but by the assumption, external to what is actually being said, that Cicero wants his client to find favour with the judges and is therefore unlikely to disparage him in front of them. But note that the subsidiary supporting generalization will not be a rigorous, exclusive one such as 'Cicero always refers to his client in favourable terms', because the orator will be willing, in the interests of appearing impartial and realistic, to admit that his man has a few peccadilloes, and will want also to ask rhetorical questions that employ derogatory predicates. So the relevant supplementary generalization itself takes only a loose or tentative form, like 'Cicero will tend to use such and such expressions',

and appeals to rather different considerations from those in the 'sunset' example. This latter feature, the fact that different *sorts* of observations can legitimately be appealed to in the search for coherence, is another point of resemblance between the linguistic and the psychodynamic situation. For a psychodynamic 'argument back' to a patient's conflicts or anxieties may very well take account of data as diverse as the way he sits, the words he uses to describe a person, the fantasy he has to a Rorschach blot and the way he spends his money.

But more important for the analysis of the logical scheme of psychodynamic argumentation is the demonstration, with the aid of the translation analogy, that rational 'arguing back' *can* be done by the aid of coherence criteria in a system whose law-like generalizations are of a loose, 'tendency' sort; and in which the subsidiary propositions that provide sign-posts to coherence, by narrowing down the range of possible alternatives left open by the basic 'loose' generalizations, are themselves of the loose, 'tendency' variety. Now how do 'tendency' propositions function logically?

III

They must be distinguished in the first place from statistical probability claims of the form: '60% of A's turn out to be B, therefore the probability of this A turning out to be B is 0·6'. Obviously the psychodynamist is not usually in a position to make this sort of claim about the connexion between particular behaviour and a given psychopathology: and in any case it may well be a mistake to suppose that a tendency statement logically resembles such a probability formulation. Nor does it even imply, necessarily, an unquantified majority-claim of the form: 'Most A's are B'. For, although it certainly conveys something stronger than merely 'some A's are B', it may do no more than postulate a systematic connexion between A's and B's that is firmer than any systematic connexion between A's and any class of things (events)

that are 'not-B'. Thus if it were the case that 40% of A's turned out to be B, 20% turned out P, 10% turned out Q, 10% R, 10% S, and 10% T, there would still be *some* sense (howbeit a limited one) in which 'A's tend to be B's (understand: 'rather than anything else in particular'); even though it would also be true to say, in this situation, that the *majority* of A's are *not* B. Braithwaite (1955) has suggested, for instance, that the loose proposition 'A's tend to be B's' is explicable as the 'tight' proposition 'All A's that are C are B's'; where C represents an unknown constant. This in turn might be rendered: 'If something is an A, then, provided that a certain (unspecified, not yet isolated) condition *also* obtains, it will be a B'. Such a reduction draws attention to an unidentified intervening variable whose presence or absence determines whether a given A in fact turns out to be a B. This suggestion seems to me particularly relevant to the complaint that psychodynamic hypotheses are such that they can 'cover' the case where A turns out not-B as well as the one where it turns out B. But, before returning to this as a final point, there is a little more to be said about the rationale of working with tendencies and coherence criteria.

If, when asked to explain a certain feature of a patient's behaviour the psychodynamist says, 'A conflict of type X tends to produce this sort of behaviour', that would leave open the possibility that some other determinant was in fact responsible: and according to the strength of the tendency for the postulated systematic connexion to exist, there would be greater or less likelihood that the patient has *not* got an X-conflict. That is to say, in so far as he is relying on only a likelihood generalization, there exists a certain *un*likelihood that the conclusion 'the patient has an X-conflict' is correct. The investigation of this claim does not necessarily take the form: 'If and only if he has an X-conflict, then this and that will be observed under these and those conditions'. It is important to note that the argument is not that if such a

conflict exists then such other things *must* be the case: but rather it is that in so far as such other things as *could* arise from the postulated conflict *are* the case, to that extent it becomes less *un*likely that such a determinant does exist. To the extent to which other behaviour can be shown to conform to the sort that *could* be produced by (among other things) that particular conflict, to that extent the likelihood that such a conflict is *not* present is reduced.

This negative formulation has the effect of establishing a parallel with the notion, fashionable in the field of experimental investigation, of refuting the null hypothesis: which notion is itself a special application of the general methodological attitude that in principle hypotheses are 'tested' not by showing directly that '*p*' is true (where '*p*' asserts the presence or activity of a certain variable) but by showing that the counter-assertion '*not-p*' is false. According to this scheme, a hypothesis is 'confirmed' in so far as its contradictory continues to be falsified by the evidence. In practice this 'refutation' often takes the form of demonstrating that there *is* a statistically significant relationship between certain variables, or between certain conditions and a particular effect, *contrary* to the expectation of the *null* hypothesis that there is *no* such association between the variables concerned. Such a formulation serves also to remind ourselves that, in accordance with Occam's 'razor' and the principle of parsimony, the onus is on the one who wants to 'multiply entities' ('*entia non sunt multiplicanda...*') to demonstrate, or to persuade us, that we *cannot* get on *without* his postulate: in other words, that his postulate is *not* in fact '*praeter necessitatem*',—'beyond necessity'. The more data that are made coherent by such a postulation, in the sense that it is shown by appeal to subsidiary tendency-laws and intervening variables that they *could* have arisen from the postulated factor, the more the *un*likelihood is reduced that such a factor is at work. And it is not merely the *number* of data additionally subsumed in this way that lends support to the original contention, but also the oddness, the inconsistency, or, in terms of information-theory, the 'improbability' of the observations so covered.

This tacit appeal to what might be called the principle of cumulatively diminishing unlikelihood used to be made, I gather, although in a more rigorous technical situation and in the context of a slightly different methodological scheme, when deciding whether a pair of twins is identical by considering how many physical features they have in common. The more specific points of identity there are, the less likely it becomes that there is *not* a general genetic identity; although for any particular touchpoint, taken separately, there would be a considerable probability that it was not the result of a universal genetic congruence. It is thus the accumulation of data which *could* result from a given postulate, but by no means *must*, (that is to say, of observations that would be made *if* X were true, but by no means *only* if) that progressively reduces the initial residual unlikelihood of that postulate being responsible. And this same principle is also, I think, explicitly at work in a less structured social situation that we are all familiar with, namely this. A friend tells you that he met a man at a party the other evening who said he was a physicist and came from Wiltshire: you think this sounds like someone you know, so you ask whether his name was Bill Jones. Your friend says that he did not catch the name; so you say 'Was he a tall chap with glasses?' Your friend says yes, tallish and glasses certainly. You say, 'Was he married with three children?': your friend says that he did not gather anything about his marital status. And so it goes on. But there comes a point, or there *may* come a point, when you feel you can safely, that is reasonably, say, 'It must have been Bill Jones'. By establishing a range of properties that the man at the party and Bill Jones have in common, you reduce the likelihood that the first correspondence of properties noticed (being a physicist and coming from Wiltshire) was

coincidental, i.e. due to chance rather than to the man at the party actually being Bill Jones. And although the contributory propositions in the argument are never of the form: 'If and only if the man at the party was Bill Jones, could he have had big ears etc.', yet such loose hypotheticals can nevertheless culminate in a conclusion of considerable rational weight: because it eventually becomes more likely that he *was* Bill Jones than that two different men should have as many properties in common. But it is not, of course, as we have noted above, merely the number of such properties that counts: what is important is their information-content. Thus, in the absence of definite points of discrepancy, the congruence of a couple of highly 'improbable' features, such as having both a wooden leg and an uncle who plays cricket for Yorkshire, might well be sufficient to convince us.

Now, suppose we could in some sense enumerate all the significant properties of Bill Jones. Then the implied argument, from your point of view, would run formally:

(1) If a man is Bill Jones then he has the properties (1), (2), (3), (4),..., (n).

(2) P (the man at the party) had the (observed) properties [(1), (2), (3), (4),..., (n) minus x], where x stands for those items of the series (1),..., (n) which are not attributable to P because of non-observation, mis-observation, mis-recollection or forgetting.

(3) Therefore P was Bill Jones.

But this syllogism is technically invalid for two reasons: (a) because the middle term is undistributed (just as in Eysenck's Jaguar syllogism), and (b) because the second term is not identical in the major and minor premisses. This creates a certain unlikelihood that the conclusion is true; an unlikelihood which can be seen to have nothing to do with frequency probability, because it derives from weakness of grounds for belief (in this case, an invalid syllogism) rather than from observed correlations between events. But the degree of unlikelihood is reduced by tacit appeal to the suppressed 'likelihood' premiss: 'It is

unlikely that two different men have this range of properties in common.' And in the case of psychodynamic speculation about the presence of a particular conflict, etc. the parallel suppressed premiss will be something like, 'It is unlikely that a patient's behaviour should have so many features that *could* derive from such a conflict and yet *not* be so derived': and the weight of *this* claim obviously depends on the possibility of constructing alternative accounts of the same features. That is why psychodynamic speculation is most plausible when drawing a thread of coherence through behavioural phenomena that on any other count remain odd, pointless, fantastic, inconsistent, disjointed, etc.: for in this respect they have a high 'information-content'.

Let us briefly look at how this use of material might work out in practice in an actual clinical example that draws on responses given to some of the much-maligned projective techniques. Consider the case of an adult patient who comes along with, among other symptoms, a very severe stammer. A clinician of some psychodynamic persuasion might, when he heard of the case, rashly say to himself something like: 'Stammers tend to be associated with (even, produced by) conflict over inter-personal aggression.' This is rash, because there may in fact be a stronger tendency for adult stammers to be determined by some other factor: but when he learns that in this instance the impediment has resisted physical treatments, speech therapy etc. he may think the case for an emotional aetiology is strengthened. There still remains, however, the considerable *un*likelihood (depending on the strength of the alleged 'tendency') that this particular patient has such conflicts over inter-personal aggression. And this is only a relatively cautious psychodynamist at work: he may be well aware that some of his more indoctrinated colleagues would be prepared to make a further claim, that conflicts over inter-personal aggression tend to arise from the Oedipus situation and therefore to be linked with more-or-less overtly sexualized

conflicts over potency, castration-fear and goodness-knows-what. He would regard these latter extravagances as even more unlikely to exist in this case than the non-specific aggression-conflict. However, if the patient systematically produced behaviour which, taken literally or symbolically, reflected (i.e. had certain features in common with the content of) such alleged further anxieties, he would consider the *unlikelihood* of their presence reduced: so that in the end there might come a point where he would say that the patient's behaviour was so loaded with certain themes, namely with the possible effects or 'expressions' of the alleged conflicts, that it was *more* economical—it made *more* sense—to suppose that such conflicts *were* at work than that they were not. What sort of data, then, would he consider, and how would he use it?

A wide range of different sorts of behaviour would, of course, be relevant, as has been said above: the patient's descriptions of his feelings and conscious concerns, the memories he chooses to bring up in psychotherapy, the structure that he imposes (or fails to impose) on the ambiguous visual stimuli of projective material, etc. So that when, in the course of making imaginative stories to vague pictures, he seems to be more than usually disturbed by the idea of conflict and hostility, repeatedly denying that the figures in one such picture are in conflict (where most people in fact feel that such a relationship is appropriate) and completely misperceiving another picture when the theme of hostility to an authority-figure is obvious to most people's way of thinking; when, in another, he speaks disparagingly of the figure whom he sees as dominating the scene; when he later writes an unnecessarily aggressive and critical letter to a senior doctor who is treating a friend of his; and when it emerges that he has been an active member of a proscribed left-wing minority political party—then the psychodynamist may be forgiven for thinking that the unlikelihood of there being an aggression/authority conflict

has been reduced to negligible proportions. Especially when it turns out that the patient despises his father in many ways and has almost deliberately avoided identifying with him.

Similarly, with the alleged possible ramifications of the authority/potency theme. On the non-sexual aspect first: the patient, when invited to make up a picture for an entirely blank card, chooses the theme of a respected teacher or religious leader with a group of disciples hanging on his lips; he recalls in therapy that at school he developed a great admiration for his teachers' academic gowns and used to act out gown-wearing fantasies at home right up to late adolescence, and he reports that, at times of depression, academic success seems all-important to him.

But the additional, and more 'unlikely' supposition that there is a specifically sexual overtone to this concern about power and achievement will give coherence to a further range of observations that would otherwise remain odd or unaccountable. Why, in the first card of the picture-test, does he have doubts about whether the central figure, which everybody else can clearly see as a man, is male or female: why does he imagine that nothing 'positive' will happen between the man and woman that he perceives in the next card: why does he see rather sinister damaged and injured animals in the Rorschach blots, giving one response ('a cow's udder rotting away') where the confused castration symbolism is almost inescapable: why does he block, at first, to another blot that has superficial phallic features and then produce, when pressed, a fantasy in which the potency/destruction symbolism is laid on with a trowel ('a swordfish: it has a prominent spine that is extended in an extra sword on the end'): and why does he revert to the same themes of super-potency and destruction in a different guise in another response ('an aeroplane shooting out of a volcano with a real force behind it: it had to make rather a mess of the volcano')? Why does he display all this behaviour which *could* arise from the sort of

oedipal concern about sexual achievement and so on unless he *has* such a concern?

Furthermore, when the behavioural material is looked at in this light, additional data-groupings that could relate to hitherto unsuspected corollaries of the main conflicts may emerge. Thus, in this case, a perceptive and adventurous interpreter would have picked up the hint of masochism in the patient's very first Rorschach response ('a moth which has been hitting itself against some glass...') and opined that the patient was likely to have some masochistic attitudes. A tenuous thread indeed: but he would have noted also the half-conscious satisfaction in the patient's manner of reporting how he had defeated all previous types of treatment, thus keeping himself symptom-crippled. An unlikely story? But some of the unlikelihood would have been diminished by the patient's subsequent description in therapy of how as a child he used in daydreams to imagine agonizing situations from which his mother in fantasy rescued him. And when he turned up for one therapy session carrying a copy of Rousseau's 'Confessions' (the first time he had brought a book with him) the psychodynamist might well consider most of the unlikelihood dispelled.

Of course, in the previous case of the man P, the strength of the 'deriving' links is greater, in that it is at least true that if he was to be Bill Jones he *must* have had certain clearly delineated properties, and that there is little room for doubt about what counts as having, or not having, such properties: whereas in the clinical argument the main proposition is weaker in two respects. Because (*a*) it is of the 'tend' not 'must' variety, and (*b*) it attributes only a vague range of expected effects, or manifestations, to the postulated cause. This makes it possible to fit a variety of different behaviour into the predicated classes of effects, etc.: particularly when (*a*) such behaviour can be taken not at its face value (difficult enough in itself to categorize) but rather as 'symbolizing' something else, or (*b*) when the question may turn sometimes on

whether the patient shows a significant lack or excess of a certain sort of response. Now the rationale of 'symbolic' interpretation is, of course, a study in itself (see, for instance, Levy (1963)); but suffice it to note here, in the light of the foregoing analogy, that the translator has a somewhat similar problem of deciding the metaphorical or figurative meaning of an expression that cannot be taken literally. The meaning he attributes to the total phrase in such a case may therefore very well be in defiance of the literal meaning of the constituent words. But this lack of specificity, however regrettable, is a feature of the law-like propositions themselves at the present state of knowledge, which may well importantly reduce the weight that can in practice be attributed to a particular psychodynamic speculation: and it may be that the relevant knowledge is not amenable in practice, or even perhaps in principle, to being improved beyond a certain degree of vagueness. But that does not undermine the essential *ratio-ality* of the operation.

For one may argue, on the one hand, following Braithwaite, that the intervening variables implied by the tendency-generalizations are in principle specifiable, such that universal generalizations for specified conditions could, ideally, replace them: which, for psychodynamics, means establishing lower-level laws about the circumstances in which a given conflict will be repressed, acted-out, split-off, over-compensated for, etc. Or one may claim, on the other hand, in company with Ayer (1948) and Farrell, that psychodynamic explanation does not need to approximate to rigorous deduction from universal causal premises, but functions rather by formulating those postulates which 'remove inconsistencies' more effectively than others do, or by 'telling more of the story' in such a way that the initially puzzling behaviour turns out to be 'what you would expect' in such-and-such circumstances. This last paradigm programme does not necessarily rest on the discoverability, or even the existence, of universal laws: and we have indeed seen some examples of rational

enterprises that manage to function without them.

But what is the logical point of this 'telling more of the story'? It must presumably be in order to 'fill out the picture' in such a way that the picture itself can then be identified as being of a certain sort, and referred to some kind of generalization about what sort of determinants produce which sort of picture. Imagine that I cover up all but the first letter of a fairly long word. You will not be able to say what the word must be; unless, perhaps, the exposed letter is an unusual one (high information-content), like 'X' or 'Q'. The only point in asking me to tell you more of the story, in this case by exposing more letters, is to produce a configuration of letters such as can be recognized to come from one particular word rather than from any other. If there were no possibility of 'recognizing the pattern', there would be no point in telling more of the story. And how can recognizing a pattern in human behaviour contribute to understanding the person concerned, except in so far as it allows one to subsume the behavioural data under some sort of 'covering-law' generalization about how different patterns are produced? The very idea of a pattern implies some expected configuration of data conforming to some principles or system: and 'recognizing' it implies identifying, in some sense, the principles or system involved, if the 'recognition' is to be of any use. Like plotting a graph and then being able to 'see' (or work out) that it is the curve of the equation '$x = y^2$'. This 'seeing' or working out may, of course, only rarely be done explicitly and in practice: but it is important that it should be possible implicitly and in principle. For although one might say, 'I can see that there is a pattern there, but I can't tell just what it is', it would be at least logically odd to say, 'I *recognize* the pattern there, but I can't say how it goes'.

This situation has to be distinguished from mere difficulties about attributing logical names to sense-data. In those cases one may perhaps want to say, for example, 'I recog-

nize the colour, but I don't know whether it's aquamarine or turquoise' (i.e. '...I don't know whether to *call* it "A" or "T"'): or certainly, 'I recognize the face, but I can't put a name to it'. And the full analysis of what it is to 'recognize a pattern' is, of course, not a simple matter, either logically or psychologically. There is a philosophical discussion of similar questions, such as how one 'understands the system' on which a series of numbers is constructed, in Wittgenstein (1953).

It seems to me, then, that 'story-telling' is relevant to understanding only because, and in so far as, patterns may emerge: and that pattern-weaving is useful only to the extent that it exposes among one's data systematic relationships whose 'equations', in terms of empirical determinants, can in principle be established. (Or if one wants to say that there are *no* such equations, what purpose is served by drawing more of the graph?) For, in the absence of this last condition (equation-writing), there is nothing to prevent a man, faced with what merely seems to *him* a familiar pattern of behaviour (or with a spurious, irrelevant, etc., pattern), mistakenly saying 'Ah, now I understand' when he doesn't really understand at all. Consider the implications of Farrell's (1963) point that a Jungian and a Freudian may 'see' different patterns in the same psychoanalytic material. In short, if the data are admitted to be susceptible of rational explanation (in the sense that some account, or accounts, of them may be regarded as 'true'), then there has to be some way of distinguishing genuine patterns from pseudo-patterns. As if a man were to look at some disjointed straight lines on a piece of paper and say 'Oh, I see: part of a hexagon', and someone were to correct him, demonstrating that you could not *really* make a hexagon out of them at all.

Accordingly, it is only by acting as if such 'equations' (generalizations, universal laws) *did* exist that the psychodynamist can avoid having the choice between rival 'explanations' of behaviour rest merely on relatively subjective criteria of 'goodness of fit' or of,

possibly misguided, expectation. To act in this way is to assume that there are patterns of intervening variables which systematically swing behaviour driven by a particular conflict or motive in one direction or another: and to make such an assumption would be to commit no grosser crime, I submit, than that attributed to Freud by the critic who said of him that what he had done was to 'take determinism seriously'.

REFERENCES

AYER, A. J. (1948). Symposium, 'What can logic do for philosophy?' *Proceedings of the Aristotelian Soc., Suppl. Vol.* XXII, p. 175.

BRAITHWAITE, R. B. (1955). *Scientific Explanation*, pp. 362 ff. Cambridge University Press.

BROMLEY, D. B. (1963). 'Scientific method in psychology: a revaluation.' A paper read to the B.P.S. Reading Conference.

CHADWICK, J. (1960). *The Decipherment of Linear B*, p. 82. Cambridge University Press.

FARRELL, B. A. (1961). 'On the character of psychodynamic discourse.' *Brit. J. Med. Psychol.* 34, 7.

FARRELL, B. A. (1963). Introduction to *Leonardo*, *by Sigmund Freud.* London: Penguin Books.

FERENCZI, S. (1909). In *First Contributions to Psychoanalysis*, p. 51. Hogarth Press.

LEVY, L. H. (1963). *Psychological Interpretation.* New York: Holt, Rinehart and Winston.

TOULMIN, S. E. (1958). *The Uses of Argument.* Cambridge University Press.

WITTGENSTEIN L. (1953). *Philosophical Investigations*, Part I, §§ 145–55. Oxford: Blackwell.

The function of affect

By JAMES M. ALEXANDER and KENNETH S. ISAACS*

The function of affect is little spoken of in psychoanalysis beyond the beginning made by Freud (1959) when he spoke of the signal function of anxiety. The signal function of other affects, as well as the question of other functions of affects—if any—remains unexplored. Freud (1955) said in a 1912 paper, 'The claims of psychoanalysis to scientific interest', that affective processes have the position of primacy in mental life. If this be true, then it is hardly conceivable that these affective processes exist functionlessly in the psychic apparatus.

Valenstein (1962), in reviewing Robert Waelder's *Basic Theory of Psychoanalysis*, said 'the concept of affects requires discussion beyond mere consideration of the two psychoanalytic theories of anxiety, for it is in the mainstream of psychoanalytic theory and is relevant to the basic theory of psychoanalysis'. Schachtel (1959), in *Metamorphosis*, clearly speaks of the function of affects. These and other writers who speak of affect are all quite recent, and to this point, to the best of our knowledge, no psychoanalytic writing is specifically addressed to the issue of the function of affects.

Regarding the significance of affect, there seems to be a curious ambivalence met often in such expressions as 'mere feeling' or 'just sentiment'. Dr Harry Lee, in an unpublished paper entitled 'Interest in affect theory', attributes the disinterest in affect theory to 'cultural lag which results from a social mandate typified in the Stoic ideal, that feelings and emotions be suppressed'. Where

this social ideal prevails, affect would seem to have no more vital function than the cloud of dust which trails a vehicle going down a dusty road. In contrast to this we hold affect to be the very core of vital experience of living. Our thesis is that a more correct analogy than the trailing cloud of dust would be a jet-propelled vehicle, with the propulsive jet stream being comparable to the affects.

In this paper we are attempting a beginning description of affect function, and some separation of healthy and pathological affect function. All our present metapsychological concepts are inadequate to the construction of a comprehensive general psychoanalytical theory of affectivity. Other concepts will have to be devised or elaborated. One such concept, that of the function of affect, is the subject of this essay. The present writers unequivocally assert that affects have many vital functions in addition to the signal function, and we are presenting in this paper some thoughts, ideas, and evidences of affect functions.

CONCEPTS OF AFFECTS

Benedek (1960) defines affect as manifestation of psychodynamic tendencies. From this definition—correct, we feel, as far as it goes—it is not clear whether this 'manifestation' itself is thought to have any function, or is considered as only a by-product, having little or no function.

Affects are often spoken of as being, themselves, ego functions. Ego growth and differentiation yield increased affect differentiation, and reciprocally more affect differentiation furthers ego development. As Brierly (1951) has said, affects come rather toward the middle of the reflex arc, having a sensory quality (feelings) and a motor quality (emo-

tions). Thus, all affects are related to the ego, but to regard affects only as ego functions is an inadequate view. More properly it appears to us, affects are ego experiences which, while making functional demands upon the ego, are also tamed by the ego to perform the warning function, and further to exert a motor pressure or motivation toward action appropriate to the situation.

The process of 'taming' of affects we think of as an ego process. That is the ego controls awareness of the affect, the integration of the affect, and the expression of the affect. It seems unlikely that the ego changes the quality of the affect. Thus, the affects are never controlled directly, but rather through qualities of experiencing, integrating, and channeling. The taming of affects is a matter of growth of ego strength so that the ego has better control of the affects and their effects upon the motor apparatus. The control is in the form of modulation. This renders the ego less prone to be overwhelmed by affect storms which would result in such reactions as impulsiveness, regression, loss of poise, panic, or fainting.

SIGNAL FUNCTION OF AFFECTS

In consideration of the function of affects, our starting-point can be Freud's original interpretation of affect as a signal. David Rapaport, according to Lewy (1961), said: 'Man has developed an anticipatory apparatus which is far more effective than any other animal's. This apparatus is very effective for outside events and fairly effective (anxiety and other affect signals) for internal events. These events play a causal role in behaviour. But man himself (and every organism to some degree) is a source of causes'. From this quotation we wish to single out first the phrase, 'other affect signals', which shows that Rapaport recognized that some affects other than anxiety have a signal function. Possibly all affects perform such a warning or signal service to the ego.

Concepts such as 'guilt-anxiety' or 'shame-anxiety' have gained currency in recent years, and deservedly so, for they are useful concepts. To us they mean that guilt and shame are painful affects, and when the ego foresees its having to experience them in some traumatic situation, it becomes filled with dread or anticipatory anxiety. Such facts confirm Freud's insistence on the ubiquity of anxiety, and its place of prime importance in the total psychic economy. Dread of painful affects such as shame, guilt, disgust and depression, exists as a potential in many people, and is ready to be activated in the appropriate circumstances.

This signal function may be illustrated by the affect of guilt. 'Signal' guilt does not merely apprise the ego that the person has done or may be about to do something wrong, but it has action potential capable of setting in motion reparative acts. Guilt feeling is experienced by the ego because of superego condemnation. This is the result of a judgement of some act of the present or past, or as an intention of the future, to the effect that the act is wrong, and some unpleasant result will ensue from it, particularly that of causing a breach in some important object-relationship. The affect of guilt is then a signal to the ego to desist from the act if one is in the midst of the commission of it, to refrain from the act if it is as yet only in the intention stage; or if the transgression has already been committed, to undertake appropriate reparative action. The appropriate reparative action is only begun by the perception and inner acknowledgement of having done wrong, and is followed by feeling sorry about it, wishing to make amends, and wishing to be forgiven. In religious terms, this is called repentance. The action in making of amends may take various forms, for example, by apology or restitution.

Like all other things human, guilt does not function infallibly. If the ego is too intolerant of guilt feeling, that is, the ego despairs of the reality of the possibility of forgiveness, various consequences will ensue, depending upon the individual's personality structure. Guilt may be repressed or denied, or the ego may react

with defiance, reaction-formation, or masochistic adaptation. It is failure of these defences against guilt which leads to depression or melancholia. All these latter reactions we look upon as aberrations of the proper psychobiological function of guilt which we see as being the prevention or repair of breaches in object-relationships.

The affect of shame has about the same relationship to the ego-ideal as guilt has to the superego (Piers & Singer, 1953). Shame is a signal to the ego that some impulse or act is weak or perverse or infantile, and will be a hurt to our narcissism, and creates fear that the result will be loss of love through evoking in others scorn, disgust, contempt or loss of respect. Hence, shame has the primary function of preventing behaviour which would have this effect. If, however, the shame signal to the ego has not been able to cause the ego to cease to look favourably upon some shameful id impulse, or to inhibit the gratifying of the shameful wish in action, shame feeling and the defence against it, namely, pride, may cause the person to make efforts to regain the esteem he has lost, to redeem himself. Pride, on the other hand, is sometimes anticipatory defence against shame. However, the inquiry to be pursued here is the examination of functions of affects in the psychic economy beyond the already-mentioned signal function of anxiety, and to enlarge upon the few mentions made in the literature, that affects have more functions than the signal functions.

MOTIVATION OF BEHAVIOUR

We wish to single out from the previous quotation from Rapaport the sentence, 'these (affective) events play a causal role in behaviour'. That affects play a causal role motivationally is, of course, common knowledge.

In causing behaviour, all affects are closely related to the pleasure-pain principle of mental functioning. Pain we do not regard, as does Szasz (1955), as an affect, except in a global, undifferentiated sense. The same is true of pleasure. We would make reference to a hanging-drop experiment with paramecia in which it can be seen under the microscope that when a noxious particle is introduced into the drop, and when the protozoan in its random swimming approaches the noxious particle, it swims away from it. If, however, a food particle is introduced into the hanging drop and the paramecium approaches close enough to sense it, it continues toward it. These reactions are called negative and positive chemotactic reactions. These reactions are related to a vital property of protoplasm, namely, irritability. Pleasure and affirmation are comparable to positive chemotaxis, and pain and negation to negative chemotaxis. These reactions do not seem to partake of the essential qualities of affect, but are anlage of affect.

To continue with some biological correlations relevant to the psychoanalytic structural concept of the psychic apparatus in relation to affects, we wish to sound a note of caution to the effect that the concept of 'structure' must not be applied too rigidly, or its explanatory value will be overburdened. The biological analogy which comes to mind is one Freud often employed: the amoeba. A pseudopod has a locomotory function, but may become a mouth, then in turn a digestive apparatus, then an excretory organ. The explanatory value of the structural concept in understanding affects is greatest if 'structure' is viewed flexibly and its explanatory value is not overtaxed.

With all this goes motor preparedness in general. Persons ready to laugh, cry, flee, fight, etc., are ready for such activity by virtue of another function of affect, namely, the effect affect has upon the premotor cortex and diencephalon. The German poet, Rilke, in his Sixth *Duino Elegy* (1939), in our opinion, captures in just two lines the essence of the hero:

In few the pressure of action rises so highly
That they are already stationed and glowing in
   fullness of heart.

Indecision, thoughtful pondering, are unnecessary for the hero. The organization of

his affectivity is such that a certain motor set exists. No more is required than merely to activate it. This assertion about the hero is but a particular example of a general principle, which is, that the dominant affects exert, mostly unconsciously, a determining effect upon the organization of patterns of motor readiness for action. This effect takes place in the premotor cortex.

Disgust is an affect related mainly to the intersystemic relationships between ego and id. The ego's reaction to id impulses is determined, of course, by the superego and ego-ideal. The id impulse in question here is the impulse to take things into the mouth. Genetically, this is most intimately related to the crawling period of infancy. At this time everything the infant gets his hands on goes into the mouth. Slowly he comes to discriminate between what is good to take into the mouth, and what to spit out. Thereafter, the fantasy of taking the latter class of things into the mouth produces the affect of disgust. The disgust signals us to reject certain things.

INTEGRATIVE FUNCTION

In an as yet unpublished paper, 'The role of hopes in psychoanalytic therapy' T. M. French & D. Wheeler show the effect of the presence or absence of hope upon the ego's integrative functions. Hope greatly potentiated the ego's integrative function. That is, these authors clearly implied that the affect of hope has a function, namely, that of the potentiating effect upon the ego's integrative functions.

DEFENSIVE FUNCTION

It is plain that the ego often uses an affect or clusters of affects as a defence against other—for that particular ego—more painful affect or affects; for instance, elation as a defence against depressive affects, and anger as a defence against guilt.

We offer one more example of the function of a particular affect, in this case, that of sadness. In the pains of hurt, loss, disap-pointment, etc.—in short, in those circumstances which cause grief and mourning—if the ego can accept the loss and can endure the sadness without trying to protest the loss away, then the ego can perform the work of mourning, and mourning does not become melancholia. In other words, the proper psychological function of sadness is the prevention of depression.

Thus, it is clear that affects serve a defensive function. Further illustrative explication of this function of affects hardly seems necessary because every analyst's experience is replete with clinical observations of this phenomenon.

TENSION REDUCTION

It is generally agreed that affects are drive manifestations which the ego has to deal with, but most frequently this is described in terms of discharge function rather analogous to the discharge of the waste productions of alimentation. However, it seems to us in this analogy that logic denies that urine and faeces have functions, but suggests that these waste products are the realities coped with by the functions of the kidneys and the bowel. That is, logically, the concept of affects as tension discharge phenomena could allow no function to affects. Instead, affects would simply present a functional demand upon the ego. Naturally, we do not deny that in the total phenomonology of affectivity affect discharge is one aspect. At least some affects do constitute a discharge phenomenon. Probably all affects are tension phenomena too. Affects in these two senses are not ego functions, but present functional demands upon the psychic apparatus and upon the body as well.

Freud apparently felt that organismal needs were simply for lowering of tension discharge of excitation. This is only a partial truth. Certain excesses of excitation do produce pain. Maintenance of homeostasis requires discharge of excessive tension. Laughter, crying, orgasm, rage attacks, etc., are affect discharge phenomena which are designed to

lower tension. Perhaps all the physiological concomitants of affects may be regarded as affect discharge phenomena. This discharge is experienced as pleasure or at least as relief of unpleasure, unless the effect of discharge of tension creates new danger, hence fresh excess tension. The psyche, however, is not in search of tensionlessness. All of us have observed painful states of hypotension, which lead to stimulus seeking for the excitation of affects to abolish these states. A state of well-being may involve much or moderate or little affect tension. Affects perform this function of the maintenance of psychic tension.

SELF-RELATION

The cathexes of the self-representations determine how one relates to oneself. The more negative the sign attached to the cathectic charges to the self-representations, the less erotic and the more thanatic the over-all organismal trends are to the adaptation to the conditions of existence. The affirmation of the self and the affirmation of life mean that the self-representations—what one feels one really is—approach the ego-ideal. Certain other additional factors such as preponderance of good over bad internal objects, the dominance of identifications with good objects, mainly benign and just introjects within the superego, allow the individual to esteem himself, to be true to himself, to be in sympathy with himself, to feel for his own dignity. From all this issue certain affects and affective attitudes, such as courage (relative freedom from excessive guilt), confidence, hope, the capacity for seriousness, dignity, poise, self-esteem, and the capacity for commitment which in turn produces the capacity for decisiveness, loyalty and steadfastness. It would take a much longer list to exhaust the affects comprising the optimal in good self-relatedness.

We regard character as the ego's habitual, characteristic, organized relation patterns. Much of this is unconscious, and can be seen most clearly in its exaggerated form in the character disorders in what Reich (1949)

called 'character-armouring'. This refers to affects tonically bound in motor patterns, forming a premotor preparedness.

Certain psychopathologic states characterized by affectlessness, like certain of the character disorders and borderline conditions, appear to the present writers to exemplify the formulations of Reich about 'character-armouring' as previously mentioned. In this condition the affects seem to be tonically bound in such a way as to produce behaviour of a truly mechanical, automatic, conditioned-reflex kind, a sort of short-circuiting wherein the warning, the signal function of affect, fails. These mechanized persons have little of inner, personal, individual, or subjective in their lives; which is to say that diminution of affectivity dehumanizes.

Certain obsessive-compulsive neuroses exhibit affectlessness, too, but the mechanism in these appears to be different. In these persons mental representations are dealt with dissociatively and counter-cathectic energies are deployed against the split-off affects so that they do not reach awareness; that is, the affects are repressed rather than tonically bound in the 'character-armouring'.

REALITY-TESTING

Reality-testing, the feeling of reality, the conviction of truth, the judgement of fallacy, depend heavily upon the affects. Psychotherapeutically, we see over and over that nothing effectual occurs in treatment unless the patient 'feels' the truth of an interpretation; that is, conviction results only from a certain affective accompaniment of a logical cognition. Our whole being in its subjective inner life, our vital appreciation of experience, is a function of affect.

OBJECT-RELATIONS

Affectivity is an important element in object-relations. Everyone recognizes that a rich, varied, mobile affectivity greatly enhances the capacity for really good object-

relations through enhancing empathy and identification, and providing a wider spectrum of delicately appropriate reactions and responses to the wealth of possibilities reality offers. Object-relationships are affective phenomena. The fact of the object relationship and the qualities of it are determined by the way the persons involved in an interpersonal relationship feel toward and about one another. Intra-psychically, the mechanisms of this are the cathexes and the cathecting of the object-representation with and by the different affect qualities and intensities.

COMMUNICATION

Consideration of the part affects play in object relations clearly brings before our attention again the communication function of affects. Correct empathic responses and brief trial identifications are prerequisite to understanding other persons. Empathy and identification are affective responses and thus affects play a major role in communication. This experiencing aspect of affectivity in relation to communication is apart from the communication function of smiling, frowning, and other motor and secretory manifestations of affects. Posture and physiognomic expression of affects are affect discharge and affect tension phenomena, but also have communication function. Everyone can more or less 'read' correctly inflexions of voice, facial expression, gesture, posture, etc. These latter belong to the realm of non-verbal expression, hence to communication. They communicate how we feel, and thus the quality of our object-relatedness.

MEMORY AND RECALL

As Rapaport pointed out in a thoughtful book, *Emotions and Memory* (1942), affect exerts a great influence on memory. We tend to remember what is meaningful to us. What is meaningful to us is rendered so by the affective investment the subject arouses in us. Thus, the subject which is affect-laden will be remembered unless the affective investment is of a too painful character, in which case it will be repressed. This is done by deployment of counter-cathectic energies. This defensive manoeuvre is different from the fact of simply cathecting very lightly some other less meaningful observations and experiences.

We suppose, also, that recall of memory also depends on affect. One writer (Ostow, 1955) has described as his view of remembering, that ideas are reviewed rapidly (as in an analogue computer), and that the affects which were once associated with those ideas are again aroused. We believe this may occur, but that also, and we believe this is more important, the 'indexing' occurs in terms of affects; that is, each affect arouses memories of previous appearances of that affect. Thus, the idea is more likely to be recalled by the affect than the other way round.

SUMMARY

In conclusion, we wish to say that in our opinion all affects probably have a signal function, that of apprising the ego of our true state of being, of what our vital reactions or feelings are in the light of our total situation. Therefore, affects have motor potential, and thus largely determine behaviour. Some affects have ego integrative functions. Many affects have communication function. Affects have homeostatic functions— the maintenance of the optimum tension state between hypo- and hyper-tension. Affects have important functions in object-relationships and in self-relatedness. Affects play an important part in memory. And lastly, we wish to point out the wide variety of defensive functions that affects have.

REFERENCES

BENEDEK, T. (1960). The organization of the reproductive drive. *Int. J. Psychoanal.* **41**, 1.

BRIERLY, M. (1951). *Trends in Psychoanalysis.* London: Hogarth Press.

FREUD, S. (1955). The claims of psychoanalysis to scientific interest. *Complete Works of Freud.* London: Hogarth Press.

FREUD, S. (1959). Inhibition, symptoms, and anxiety. *Complete Psychological Works of Sigmund Freud.* London: Hogarth Press.

LEWY, E. (1961). Responsibility, free will, and ego psychology. *Int. J. Psychoanal.* **42**, 260.

OSTOW, M. (1955). Psychic contents and the processes of the brain. *Psychosom. Med.* **17**, 396.

PIERS, G. & SINGER, M. B. (1955). *Shame and Guilt: A Psychoanalytic and Cultural Study.* Springfield, Ill.: Charles C. Thomas.

RAPAPORT, D. (1942). *Emotions and Memory.* Baltimore: Williams and Wilkins.

REICH, W. (1949). *Character Analysis.* New York: Orgone Inst. Press.

RILKE, R. M. (1939). *Duino elegies.* New York: W. W. Norton.

SCHACHTEL, E. (1959). *Metamorphosis.* New York: Basic Books.

SZASZ, T. S. (1955). The ego, the body and pain. *J. Amer. Psychoanal. Assn*, **3**, 177.

VALENSTEIN, A. (1962). Review of basic theory of psychoanalysis. *Psychoanal. Quart.* **21**, 11.

The observation and topographic study of the changing ego states of a schizophrenic patient*

By VAMIK VOLKAN†

INTRODUCTION

Federn (1955) emphasizes that the ego boundaries are flexible and they undergo progressive changes beginning at birth, and include, at various times, differing contents. The specific contents, which are at any given time included within the ego boundary, determine the specific ego state. Therefore, different ego states are correlated with different ego boundaries. Weiss (1955) reports that some changes of the dynamic ego boundaries occur in different situations during everyday life of the individual. 'However', he adds, 'the ego constitutes a continuity and struggles to establish and maintain, in every state, its coherence and integration.'

In schizophrenia, disturbances in ego boundaries occur and changes of the ego states of a schizophrenic may be more dramatic; however, these changes may not be observed by the therapist because they may be overlaid or obscured by other events. Abse (1955) states that 'The clinical features in a case of schizophrenia are referable to two categories of events—one of these is due to the regressive process and the other to restitutional efforts...as far as the clinical picture is ultimately concerned because the regressive process and reactive attempts at reclaiming reality relation are contemporaneously present; at one or another moment of time, one or the other may be more in evidence. In

addition to this entanglement of categories of events, various results ensue, more or less contemporaneously from the regressive process and from the restitutional process, respectively. Thus events resulting from regressive process alone may evince themselves at various levels simultaneously or consecutively during a short time. So the clinical picture is both confused and confusing.' Because of this 'confused and confusing' clinical picture in schizophrenia the therapist may have difficulty in clearly observing the changes in the patient's ego states on the one hand, and the schizophrenic may not have a chance to report these changes on the other hand. Federn (1955) advised therapists to watch the psychotic's facial expressions to notice any changes in his dominant ego state. He writes that 'When a psychotherapist speaks with a psychotic patient he must be aware that the ego levels of the patient are subject to change as are his words and behaviour'. The purpose of this paper is to report the case of a young schizophrenic woman who had a hypertrophy of self observation as a defence and because of this hypertrophy was able to report changes in her ego states. The changes of the ego states of this patient are topographically examined by drawings. These drawings were obtained by simply demonstrating the patient's own explanation of her symptoms.

The changes of the ego states of this patient, most of the time, seemed to follow some peculiar patterns. In this paper the author's objective has been to apply certain mythological, theoretical and clinical knowledge to those patterns of changes of the patient's ego states.

CASE REPORT*

A. *History*

The patient, Mrs F., is a 31-year-old white female who has been married for 14 years, and who, at the time treatment began, lived with her parents in the United States while her husband worked as a civilian in the United States Army Camps in Germany.

Presenting problem. Mrs F.'s primary complaint was that she had too many 'selves' or 'frames of mind' in her personality composition. These 'frames of mind' came and went, but none of them 'held' for any length of time. She talked about two 'main controls'—namely, her 'left' and 'right sides'—and usually referred to these 'sides' as her 'double personality'. She also complained of being in a 'circle' at times. Somatic complaints were present; they took the form of peculiar headaches which might change quickly from one side of her head to the other, but were more frequent on the left. Mrs F. also felt her head was being pulled out in one direction or another.

Home in which the patient was reared. Mrs F. was the eldest of three children. She had a brother 3 years younger and a sister 13 years younger. The mother was a very controlling and demanding woman who came from a 'musical and temperamental' family. The mother always wanted to be a great pianist and from the beginning she tried to fashion the child to be what she was not.

The father was a passive individual who 'would do anything to avoid unpleasantness'. He hated making decisions about family affairs, a fact recognized by the family. His wife referred to him as 'wishy-washy'. He seemed to have difficulty showing any affection.

Mrs F.'s brother suffered from bronchial asthma when he was a child and sought the patient's aggression for protection. The patient felt that his asthma was psychogenic.

The sister was born when the patient was about 13 years old. The mother reported some non-specified jealousy between her daughters. The sister had a rejecting attitude toward the patient during her illness.

* Outline for the case presentation was adapted from a form devised at the Psychoanalytic Clinic for Training and Research, Columbia University, New York City.

Personal history

Infancy. When Mrs F. was born, the mother was seeking a career for herself as a pianist and emotionally was unprepared for a child. The pregnancy was not planned. The mother raised the patient according to a book which advocated leaving babies alone—no unnecessary handling, hugging or kissing. The mother reported that the baby was 'so beautiful' and she thought that one day the patient would be a great musician instead of herself. While the child was left alone in her bed or play-pen, the mother played the piano and communicated with Mrs F. by music. The patient was breast-fed. However, after a few months she started crying and a physician diagnosed her condition as 'hunger'; after this she was bottle-fed.

Childhood. The mother reported that the patient was a nervous child and very active. The child walked and talked early. According to the mother, toilet training was no great problem; it was handled more or less without undue difficulty.

Mrs F.'s earliest memories were of going 'around and around' in a play-pen and swallowing a piece of a razor. She recalled her mother's pushing her 'this way or that way'. Being disturbed by this she tried to figure out a way of handling herself according to her mother's 'pushings'.

The patient's difficulty of getting along with other children became more pronounced when she entered grammar school. She was not a good student and tended to get nervous when pushed by her mother and the teacher toward excellence. At home the mother tried to teach the patient how to play the piano, but this ended with disappointment for both.

Adolescence. Mrs F. reached puberty at thirteen, soon after having measles. During the same year the mother was pregnant. In talking about her mother's pregnancy, Mrs F. went on to describe how she had a dream before her mother's pregnancy about having a sister who would be blond. (Mrs F. is dark.) She drew a picture of the sister in the dream and put it first over her own bed and then under the pillows of her parent's bed. Soon after this the mother became pregnant and had a baby who looked like the baby in the patient's dream. The parents joked about the resemblance of the picture Mrs F. had drawn and the real baby.

The patient also reported having such signs of pregnancy as morning sickness and gagging during her mother's pregnancy. She had heard her parents having intercourse and thought that her mother was 'rough' on her father.

The mother thought that Mrs F. became 'hot tempered' after the age of thirteen. It was well known fact that after the sister was born the mother's 'musical attention' turned to the new-born-baby.

Adulthood. At the age of 17, after quitting school in the tenth grade, Mrs F. married a young man who was liked by her parents. A year after her marriage, a daughter was born—clearly before a child was wanted. Mrs F. did not seem to adjust to the ordinary responsibilities associated with being a wife, housekeeper and the mother of a child. Despite her pulchritude, her husband related to her with indifference. When Mrs F.'s daughter was 18 months old, Mrs F. separated from her husband and lived with her child at the parent's home. After 6 months of separation, she and her husband started living together again.

About 7 years ago, the patient's husband went to Europe and worked as a civilian at the United States Army Camps. After staying in her parent's home for 6 months, the patient and her daughter went to Europe to join him. Mrs F. spent $2\frac{1}{2}$ years in Europe; first in Austria, then in Italy, and then for a longer time in Germany. To attempt to stabilize a faltering marriage, the patient and her husband brought into their German residence a 4-month-old German boy who they hoped to adopt after a trial period. Five months later, the child was taken from them because the boy's real mother would not agree to his leaving the country.

After suspecting her husband of infidelity, Mrs F. had sexual relations with a German gynecologist and confessed her guilt to a minister who first understood and accepted her, and then blamed her. The gynecologist rejected the patient by coming to the United States. While in Germany, Mrs F. trusted her maid and talked to her about her problems. The maid encouraged Mrs F. to have the love affairs but then gossiped about her.

The patient had 'sticking out' ears like her maternal grandfather who was a strict Methodist minister. In Germany, Mrs F. had plastic surgery done on her 'sentimental' ears and suffered from severe anxiety while she was in hospital with bandages around her head.

Present illness. Mrs F. sought marriage counselling and was interviewed by a female psychiatrist at the American military base where her husband was stationed. Fearing a breach of confidence, she went to a male German physician who was in his forties and who was practicing psychiatry. Over a period of a month, during which time she was seen by him three times per week, he reportedly used hypnosis in treating her. Mrs F. complained that he had shown her too many of her 'selves' and feelings that she did not know how to handle. She said, 'It is as though he took me apart and did not put the parts together. He scrambled my mind. When I was up here, he took me down there and I can't seem to pull up.' The therapy was terminated at his suggestion, though the patient felt the process was incomplete. Soon after this, Mrs F. returned to the United States to her parents' home with her daughter, leaving her husband behind in Germany.

When Mrs F. returned to the United States to live with her parents, her productions were generally unintelligible, but chiefly concerned the German psychiatrist who, she felt, adversely influenced her thinking. On one occasion, she hallucinated and saw the German physician in the kitchen. She thought that those about her assumed mannerisms of the German psychiatrist with supposed intent of disturbing her.

During a 2-year period subsequent to her return to the United States, the patient had two diagnostic evaluations at two different university psychiatric clinics, and was admitted to a state hospital for a few months on two different occasions. She was given chlorpromazine hydrochloride, in the state hospital on both occasions, and was instructed to continue taking the drug as an out-patient; but the patient refused to continue medication shortly after leaving the hospital each time on the grounds that her 'self-control' was threatened.

Between her stays in the state hospital she visited a physician uncle in another state, for a few weeks. Upon his suggestion she was hypnotized again, this time by a psychologist. Reportedly, this hypnotic session ran about 6 hours. Also, during her visit to this uncle Mrs F. called her previous German gynecologist-lover by telephone. At that time he was practising in another part of the United States. He cut their conversation short by telling Mrs F. that he was engaged to be married.

The patient was primarily incapable of taking the responsibility for the care of her daughter, who was looked after by Mrs F.'s mother. At times the patient seemed angry about this arrangement and occasionally exhibited a violent temper, attacking her mother with hair-pulling and throwing objects. Mrs F.'s mother was not only irritated by such aggressive behaviour but also the patient's playing the accordion for long periods of time or following her about the house while talking about herself.

After her second stay in the state hospital, Mrs F. was seen as an out-patient for about 8 months by six medical students under supervision at a university psychiatric clinic. The students' general reaction to her was 'frustration' as they were not able 'to get anything out of her' because she would talk about 'her sides and nothing else'. Later Mrs F. was admitted to the university hospital's in-patient service.

B. *Psychotherapy*

The writer started to see Mrs F. 1 month after she entered the university hospital because her previous therapist left the service. She stayed in the hospital for 10 months. During the first interviews with the patient, the writer was struck by sudden changes in her manner, tone of voice, movements, moods and body and facial expressions. At times, sad—even despairing—expression suddenly gave way to lighter, more cheerful feelings. She became coy and coquettish. She displayed a violent temper. She might stop in the middle of a sentence, or even a word; after staying silent for a while or talking about something else, she would only occasionally return to the previously interrupted thought.

From the very beginning, Mrs F. frequently referred to her 'left and right sides', different 'levels', 'frames of mind', or states of being 'twisted up', 'scrambled up' or in a 'circle'. She gave the changes of her 'sides' or 'frames of mind' as reasons to discontinue the topic of discussion. Statements like these were heard very often: 'I can't answer you, because my right side is holding back'; 'I could talk about this if I were on another frame of mind'. Owing to the above-mentioned continual changes, a natural conversation between the therapist and the patient was impossible. The therapist accepted the patient's difficulty of relating verbally to others and patiently waited for her to complete her

'circle' or other interpsychic changes and to infrequently return to the same 'frame of mind' in order to finish a story or statement.

During the first 2 months of her stay in the hospital, she could not remain seated longer than a few minutes at a time. She moved around and around in the room. It was during this time that Mrs F. reported feeling as if she were in her play-pen, going around and around. It was felt that the patient was trying to re-experience very early interactions with her mother in the therapy situation. This became more evident when she asked that her accordion be brought to the hospital. Mrs F. at times spent a great deal of time playing her accordion and during many interviews she preferred to communicate music-ally instead of verbally. At times, she identified the therapist with the German psychiatrist and reacted with extreme anger or seductive behaviour whenever the therapist made some motions that reminded her of the German physician.

Mrs F.'s room was usually filled with cigarette butts and half-empty soft drink bottles. She also kept her clothing dirty. According to a pro-gramme, the nurses helped her to clean herself and her room. This programme was based upon a controlled permissive attitude. When she made hundreds of small burns on the furniture in her room, this was controlled with interpretations as well as some regulations.

Mrs F. had a tendency to divide the nurses into 'good' and 'bad' nurses; and when the 'bad' nurses were on duty she often remained in her room, playing her accordion. She was able to communicate verbally with one particular 'good' nurse. Unfortunately, this nurse suddenly left her career. Mrs F. later blamed this nurse for a long time as being a 'double-talker' like her mother. She had thought the nurse was telling her lies, while seeming to be a friend; when in reality she was planning to reject her.

During part of her hospital stay, a bedtime bath was prepared for Mrs F. by the nurses. A glass of milk was also available to the patient. When the therapist started to spend long hours in treatment with another female patient, sibling rivalry on the part of Mrs F. became obvious. Upon her request, a peanut butter sandwich also became available at bed time. (It was known that soon after the birth of a sister the patient went through a period of eating peanut butter sandwiches.) It was observed that Mrs F. did not usually drink her milk in the hospital; she reported that she

became ill during her infancy in a condition diagnosed as 'hunger'. Each morning, Mrs F. was awakened by a nurse for breakfast. However, she was not urged to come to the dining room and usually missed her breakfast. She displayed tantrums whenever the nurses forgot to awaken her.

Some of the above-mentioned procedures, which aimed to consider Mrs F.'s illness but at the same time to activate the well part of her ego, were discontinued when the patient's general condition improved.

Mrs F.'s relationship with the therapist changed according to the changing 'sides' or 'frames of mind'. Later she was able to 'carry on' with fewer and less dramatic changes for a couple of days' duration. Near the end of her stay in the hospital, Mrs F. started to mention her 'sides, frames of mind, circles, etc.' less frequently and was able to develop some interest 'outside of herself'. She was given permission to leave the ward alone. She actively and somewhat constructively became interested in the future of her marriage and the welfare of her child. She was able to establish some friendships with the other patients in the hospital. However, her friendships were based upon seduction and demand.

At the beginning of her stay in the hospital, her husband came from Germany and visited Mrs F. on two short occasions. He made it clear to everyone that he would not like to be involved in the patient's care, but wanted only to help with her hospital expenses 'in order to get a divorce when she is well'. He returned to Germany after a short stay in the United States.

The parents could not visit regularly because the mother was prone to small accidents—such as falling. On a few occasions the mother's arthritis flared up the day before a planned trip (fifty miles) to the hospital and only the father came to see Mrs F. The sister visited the patient only one time in 10 months, because she was 'ashamed' of Mrs F. Mrs F's daughter's occasional visits usually ended stormily because Mrs F. accused her mother of over-controlling her child.

The patient had to leave the university hospital due to financial reasons. The mother reported that she would let Mrs. F. stay at the family's home if the patient obeyed her.

After leaving the hospital Mrs F.'s improvement continued for a short while. She complained about the misunderstanding at home and entertained thoughts about the therapist magically finding a place for her to live close to him. When this wish did not materialize, Mrs F. expressed her disappointment with extreme anger. The parents could not bring her to the university hospital for out-patient interviews more than once a week. Though the therapist moved to another hospital, he continued to see her in the first hospital. The patient saw this as a rejection and developed clear paranoid ideas. It was observed that when she was 'nice and co-operative' at home she was aggressive during the interview hour and vice versa. Mrs F. reported that she had to spend more time at home than 1 hour per week with the therapist; therefore, she would choose the therapist as the 'bad mother' in order to have a more comfortable relationship with the real mother at home. After this a negative transference developed and resisted verbal interpretations. The patient became destructive and very aggressive during therapy. It was felt that out-patient treatment on a once-a-week basis would be impractical and she was advised to seek another admission to a state hospital. She has been in the state hospital over a year. Periodic conversation with her physician at the state hospital indicated that Mrs F. went back to her preoccupations with her 'sides' and 'frames of mind'.

THE OBSERVATION AND TOPOGRAPHIC STUDY OF THE CHANGES

It is known that a Chinese thinks of a tree and draws a figure like a tree when he wants to express himself by writing. When he sees the morning sun behind the trees, he calls this natural phenomenon the East; this abstract thing is expressed in writing by combining the symbols of two concrete things; the tree and the sun. The topographic study in this paper, in a general sense, is like Chinese writing and some abstract things which were told to the therapist by the patient are expressed graphically through drawing.

Mrs F. came to therapy with the main complaint that she had a 'left' and a 'right' side and referred to these 'sides' as her 'dual personality'. She spoke about a 'bar' between these two 'sides'. By drawing a line with a circle on each side of it the patient's own explanation of her symptoms was simply demonstrated (Fig. 1).

Bar

Left side   Right side
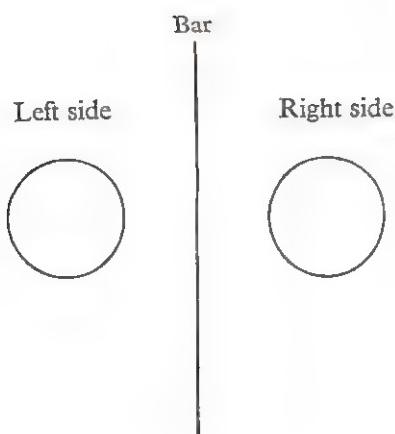
Fig. 1

During the therapy, it became clear that when Mrs F. reported being on the 'left side', she would speak gently, behave seductively and become generally passive. When she reported being on the 'right side', she would speak roughly, might have a temper tantrum and throw things on the floor or at the therapist, call the therapist names and became generally aggressive. When she played her accordion during the interview hours, her passiveness and aggressiveness could be noticed in her music. When the verbal communication in therapy became more meaningful, she reported that she could not stay on the 'bar' as 'there is no place to land on it'. Her 'left' and 'right' sides were not static; therefore, she could go 'backwards' on both 'sides'. The process of going 'backwards' was associated with regression. Therefore, it was felt that Mrs F. was talking about two regressions: one through the 'left side', the other, through the 'right side'. The ends of both regressions were the same and the ends were on the 'bar'. The patient called this endpoint 'complete backwards' (Fig. 2). At this place 'the left and the right are the same' or 'both the left and the right are present'. Her condition at 'complete backwards' was referred to by the patient as being 'balanced'. When Mrs F. was observed at 'complete backwards', she was usually speechless, her eye lids were heavy, she was almost motion-

less. Her subjective experience at that level—as she expressed later—was that there was no verbal concept. She could think with music and knew what she was thinking in music, but no words could explain her thoughts.

Bar

Left side   Right side

Complete backwards
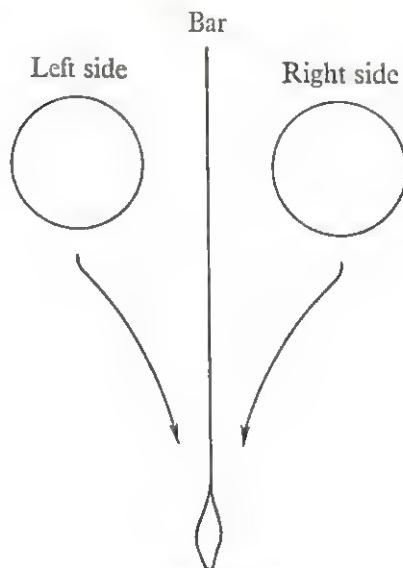
Fig. 2

When Mrs F. approached 'complete backwards' early in the treatment, she used to walk around and around in the room and report how her mother had repeatedly told that she had spent unusually long periods of time going around and around in her play-pen when she was a very small child. Before she became speechless, Mrs F. stuttered, talked only with difficulty, and belched. When she approached 'complete backwards' from her 'right side', she coughed in a particular manner but there was no coughing on the 'left side'. Later she reported that her father used to cough in the same manner and her brother had suffered from 'psychogenic' asthma attacks from childhood until adulthood.

When the patient wanted to show the therapist her 'right side' she asked that a painting be brought to the hospital. This painting, by an Italian artist when Mrs F. was in Italy, showed the patient from her waist up, holding her male cat, Maxie. Both the patient and her

mother emphasized the patient's face in the painting. The mother said that the patient's eyes in the painting looked weird. A photograph of the patient, brought by 'mistake' instead of the painting, showed Mrs F.'s 'left side'. When the painting was finally brought, she kept both the photograph and the painting in her room. As she then had her two 'sides' outside herself, she talked about them more easily.

'The Photograph' had a gentle, soft voice. 'The Painting' spoke roughly. 'The Photograph' was a wife and a mother. Either one could be a lover. 'The Photograph' looked 'soft'; 'The Painting' did not. The patient reported that 'The Photograph' was 'the mother's child whom the father liked' and 'The Painting' was 'the father's child whom the mother liked'. She was 'carrying on with the Photograph' before she went to Europe, where 'The Painting' grew up, but she also held on to 'The Photograph'. 'The Photograph' and 'The Painting' always knew each other.

Different levels of her 'left and 'right' sides were referred to by the patient as different 'frames of mind'. Mrs F. seemed to be a traveller as she went from one 'frame of mind' to another almost constantly. She called the changes of 'frames of mind' as her 'circles'. Two main circles were here 'left and right circles'. As it can be seen by the topographic study (Fig. 3), these circles might include different numbers of 'frames of mind' or be shorter or longer. The patient would also be on 'circles' which might include 'frames of mind' not only of one 'side', but both 'sides'. Theoretically, when in this kind of 'circle' (Fig. 4), the patient at (1) would be talking gently and softly and would appear feminine. Towards (3) and (4) she would become childish and also would tease the therapist seductively. If (4) is close to 'complete backwards', she might stutter, belch or lose her ability to speak. At (5) she would become tomboyish, and towards (6) and (7) would become more aggressive or even destructive. Clinically, these kind of changes were observed
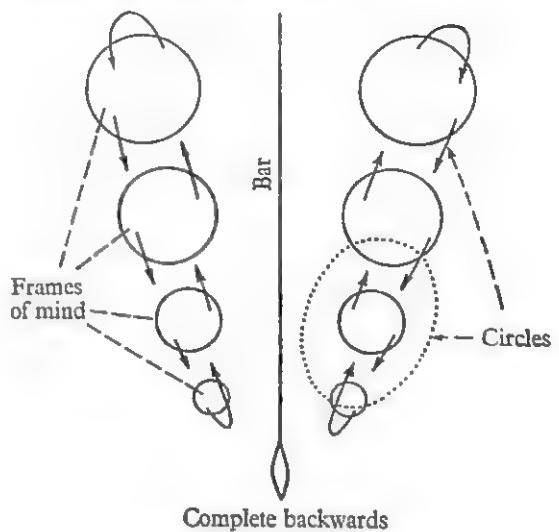
Fig. 3

and, at times, all these changes or completing one long 'circle' took place in a few minutes.

Mrs F. also talked about 'up' and 'down'. It was felt that 'up' and 'down' indicated her moods. For example, when she was 'left-up', she could be expected to have a manic behaviour, be very seductive, and wear a lot of make-up.

Another term which she often used was 'reversed'. To illustrate. When she showed the painting to the therapist for the first time,
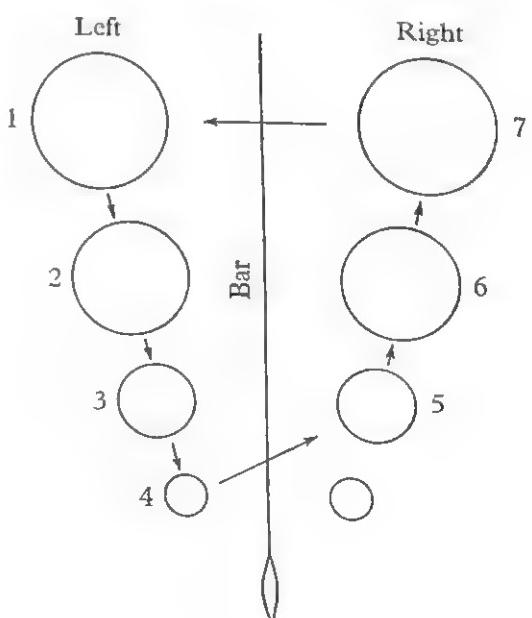
Fig. 4

she thought that the therapist would not accept her 'right side' and therefore said, 'The painting is my left side'. Then she added: 'I am reversed, do you understand?' By being reversed, she was protecting herself by denial.

Her other popular terms were 'being twisted' and 'being scrambled-up'. During her 'twisted' condition there was a rapid change from the 'left' to the 'right' or from the 'right' to the 'left'; therefore, the 'circle' form was gone. 'Scrambled-up' represented an advanced form of 'being twisted', as her moods were involved in the changes (Figs. 5, 6).

During the main 'circle form' of regressions (the left and the right circles) Mrs F. sometimes felt that her body was 'pulling down' on one side or another; however, she reported that her bodily sensations were mostly felt on her face. She explained that the most painful experiences were to be 'twisted' or 'scrambled-up'. One also could observe what the patient was going through during these experiences. She would report severe headaches and a feeling that different sides of her face were pulling out and in. In order to keep her head and face from splitting or pulling to one side, she would press and

Scrambled up
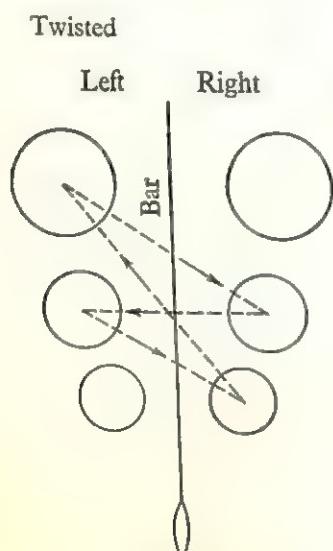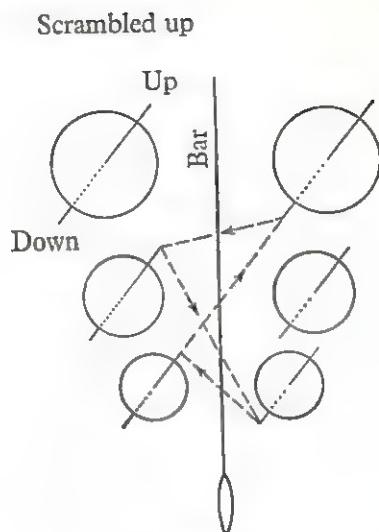
Fig. 6

protect them with her hands or pull at her hair and some muscles of her face. She could not stand up as she seemed to be dizzy.

Words like anger, hate, sex, or statements about her relationship with her parents would put the patient in 'twisted' or 'scrambled-up' conditions. Her only escape from these situations was to go to 'complete backwards' where she was in 'balance'. By playing Austrian waltzes or Italian and German songs with her accordion she might put herself in 'balance'. Sometimes, however, she had to play nursery rhymes to be in 'balance'.

DISCUSSION

'Complete backwards'

Whitehorn (1953) writes: 'Among schizophrenic patients...one notes a very general resentment of control and a yearning for "independence"....Such a desire [for independence] is not, as it might be for others, a practical wish to have freedom to work out a definite concrete constructive ambition. Most typically the schizophrenic patient's desire for "independence" is a resentment against influence. The influence which is resented is not purely imaginary.' Mrs F. reported that the mother had pushed her 'this way' or

Twisted

Fig. 5

'that way' during their early relationship and she felt 'tired' of pushings. She wanted 'to free' herself from mother's influence. She associated such freedom with very early speech. She said: 'I learned to talk even before I learned to walk. This is written in my baby book.' She stated that instead of letting herself be pushed 'this way' or 'that way', she started to sense which way the mother was going to push her and then would behave in a way acceptable to the mother. Mrs F. thinks that her 'dual personality' then started. The 'complete backwards' is a representation of a period in the patient's life before the 'dual thing' started. At 'complete backwards' opposite feelings and reactions are in balance, in other words, the opposites are undifferentiated.

Investigation of 'complete backwards' provides certain clues that the patient's emotional experiences in Europe (where she became clinically ill) were connected with her emotional experiences as an infant or a very small child. She did not know the German language before she went to Europe. Because she started to talk in German as she went toward 'complete backwards' one time, the therapist, assuming that 'backwards' represented a regression toward infancy, asked the patient how she could speak the German language when she was at 'backwards'. Her reply was: 'Don't you see, I was learning a new language. You will be surprised how soon I learned the German language.' As it has been reported in this paper, the patient went to 'complete backwards', where she was in 'balance', by playing nursery rhymes as well as songs of Austrian, Italian, or German origin. When she was a baby, she was in a 'musical family'. In Europe she found herself in 'the most musical countries of the world; all of my neighbours played the piano continually'. Music was an important role in communicating with her mother when she was an infant and an adolescent, until the mother's 'musical attention' was turned to the patient's sister. Music was on both sides of the mother's ambivalence. (1) On the part of rejection: the mother would have more time for her music if she did not have to spend time with her child; (2) on the part of acceptance: in phantasy she thought that the child would take her place and become a great musician. Because of this ambivalence, the mother never became a good teacher and the child never became a good student.

At 'complete backwards' the patient, at times, assumed a foetal position and covered herself with a bed cover. On one occasion she sat down and remained motionless, folding her legs like a statue of Buddha, and later told the therapist that she had sat in that position in order that the therapist might understand where she was. At the level of 'complete backwards' the patient's communication was non-verbal. However, she tried to communicate her inner experiences at 'complete backwards' verbally after she was away from that level.

One of the most important findings of Federn was that ego states of earlier ages do not disappear but are only repressed. This can be experimentally proven. Weiss (1955) writes: 'In hypnosis, a former ego state containing the corresponding emotional dispositions, memories, and urges can be re-awakened in the individual'. Mrs F. believed that she 'really' became ill after she was hypnotized. In her case the self observation of previous ego states was possible.

Schizophrenia in an adult occurs after the person has achieved some psychic differentiation. When Mrs F. went to primitive ego states, having had and still possessing a more complicated and differentiated psychic apparatus, she expressed the primitive ego states in a different way from a child in these phases.

The relation of the problem of ambivalence, bisexuality, aggressiveness-passiveness to the symbols of 'left' and 'right'

When the patient talks about her childhood reaction to her mother's opposite 'pushings', she refers to a psychic system — namely, her 'sides' or the 'dual things' —

which never enabled her to deal with the ambivalence. Because of this psychic system the patient would never be in the difficult position of disliking and liking somebody at the same time. The ambivalence does not exist from the very beginning. When Mrs F. faced the phenomenon of ambivalence by using her 'sides', she dealt with it like a child at play who typically uses two dolls to split the mother into a good mother and a bad mother. The patient seemed to have little capacity for integrating the 'duality' of her psychic structure and the balance between her 'sides' became disturbed under stress in Europe.

Very often the 'duality' was seen in the patient's daily life. For example, she reported one repetitious dream from her childhood. In this dream the patient sees a set of twins. Once, she associated the twins with her 'sides' and reported that one of the twins was crippled. During her stay in the hospital the patient made a rug at the occupational therapy shop. When the rug was finished, it was obvious that a faulty line in the middle divided the rug into two parts. This was similar to a magazine cover which showed a brain divided into two parts. The magazine was kept in her room for a long time. Referring to this magazine cover the patient stated that her brain also was divided into two parts and at any given time she was 'carrying' herself with one of the parts.

Bisexuality seemed to be associated with the 'sides'. Searles (1961) writes that: 'In my experience, the child defends himself against mutual ambivalence of such degree in the relationship with the mother by the perpetuation, into chronological adulthood, of a symbiotic relatedness with her and by the retention—inherent in this same process—of fantasied infantile omnipotence. With, later on, the maturation of the anatomical and physiological sexual apparatus, a sexual differentiation comes to be required at a psychological level, too, the acceptance of oneself as either male or female, which runs counter to the infantile fantasy of being both—of being, in fact, the whole perceived world.' This author also states: 'The great problem of the preschizophrenic person, of course, is that, in keeping with the perpetuation, at an unconscious level, of the undifferentiated mother-infant stage of ego-development, he has not achieved any deep-reaching sexual differentiation of himself and perceived others into either male or female. The struggle to achieve such differentiation is probably one of the internal causes for his conception of all possible human feelings and behaviour traits as bearing, like all French nouns, some sexual label.'

The patient condenses right-male and left-female with right-aggressiveness and left-passiveness. In order to examine the sexuality and aggressive elements of her 'sides', we chose a time in Mrs F.'s life when she owned one male and one female cat. Like 'The Photograph' and 'The Painting', these cats projectively represented her two sides.

Maxie, the male, and Marie Jane, the female, were family cats when Mr F. was in Austria. The cats were taken with the family to Italy, then shipped to Heidelberg where the family lived. The patient said she used to 'taste' the cats. 'Taste' was a slip of the tongue for 'chase'. (Orally introjected cats.) According to Mrs F., the cats were like human beings and had characteristics like persons (see Table 1).

In Heidelberg, Marie Jane fell from a window and later, after having convulsions, died. Mrs F. blamed her maid for this accident. She did not cry after the death of Marie Jane, but became quiet like the cat. After the death of Marie Jane, Maxie went wild. Mrs F. was afraid of this wildness which, of course, like the quietness of Marie Jane, was an internalized phenomenon for her; therefore, she asked her husband to take Maxie away. Before taking the cat away, her husband removed Maxie's collar. This later disturbed the patient because, 'no one ever would know that Maxie had been a pet.' After Maxie was gone, the patient felt that she 'was killed inside.' Following this she began seeing the German psychiatrist.

Table 1

THE LEFT	THE RIGHT
is passive	is aggressive
is seductive	is destructive
teases (play)	teases (hurt)
is liked by the father	—
—	coughs when is near to 'complete backwards'

THE PHOTOGRAPH	THE PAINTING
speaks softly	speaks roughly
manners: gentle	manners: rough
is a wife	—
is a mother	—
is a lover	can be a lover
is the mother's child	is the father's child
is liked by the father	is liked by the mother
was dominant before the patient went to Europe	—
always knew 'The Painting'	always knew 'The Photograph'

MARIE JANE	MAXIE
is the female cat	is the male cat
is quiet	is active
is playful	is serious
slept with the patient	—
was killed (?) by the maid	was killed (?) by the husband

During her stay in the hospital, Mrs F. reported that she used to let the cats make motions with their paws on her body as though grasping a breast for sucking. While talking about these cats, the patient made claws with her hands and reported feeling like a cat, and then made motions with her hands as if sucking a breast like a cat. Her motions first appeared to be gentle and the patient seemed to be satisfied and in a loving mood. However, suddenly her motions appeared to be aggressive and the patient seemed to be hateful.

In the case of the cats bisexuality is there, as well as passiveness and aggressiveness. In the following example the patient's opposites were identified only with passiveness and aggressiveness. She reported that when she was a child her parents were 'confused' and on many occasions called her by the name of 'G' or 'E'. 'G' and 'E' were her maternal aunts who, of course, belonged to the same sex. They represented her 'easy-going side' and her 'aggressive side'.

Other characteristics associated with the symbols 'left' and 'right'

While associating gentle-feminine and aggressive-masculine with the 'left' and 'right' sides in the case of Mrs F., it is known that other characteristics can be related to the symbols left and right. A Turkish expression 'to get up from the bed on one's left side' means that the person is hard to get along with that morning. Staercke (1914) suggested that symbolically 'right' meant heterosexual and 'left' meant homosexual, while Stekel (1911) associated these symbols with 'correct' and 'wrong'.

Gutheil (1960) writes that: 'Religious significance can be found in the symbols "left" and "right".... In general the left symbolizes the tabooed impulses like incest, criminality, homosexuality, and paraphilias (perversions). The "right" is usually representative of the just, legal, good, and accepted principles. As such it is also a symbol of marriage and heterosexuality.' Ferenczi (1945) is of the

opinion that the left side of the body is, in general, more accessible to unconscious influences than the right because right-handed persons have less conscious interest in it.

Folklore and mythology in relation to the symbols of 'left' and 'right'

We learn that the Bagobo of the Phillipines share a very widespread belief in multiple souls but have given it a special twist by distinguishing a right-hand soul which is beneficient and a left-hand soul, which is malevolent. The *takawanan* ('good soul') is associated, in native thinking, with those factors of existence which stand for life, health, activity, and joy, while the *tebang* ('bad soul') is associated with factors that tend toward death, sickness, sluggishness, pain (Benedict, 1916).

The male and female pair of Cosmic Rulers, Great Father and Great Mother, represent the opposite aspects of nature in many mythologies. One classic religious example of the cosmic dualism is the Zoroastrian Parsis. The universe is divided into two great rival camps —that of *Ahura Mazda*, and that of *Ahriman*. The first is the God of Goodness, Light and Health and the latter is a devil representing darkness, evil and disease (Edinger, 1955). Frazer (1953) reports the African legend of the first cosmic pair who were locked together in a timeless embrace until forcibly separated when their offspring was brought to birth.

More differentiated and refined expressions of these pairs on higher cultural levels are represented, for example, by the Greek Zeus and Hera, the Chinese Yang and Yin, and the Hindu Siva and Shakti (Perry, 1953). Zimmer (1946), one of the noted Indiologists of our time, explains the myth of the cosmic pair of Siva and Shakti as 'though seemingly two... fundamentally one...the absolute has apparently unfolded into this duality, and out of them comes all the life polarities'. Gordon (1949) writes that the philosophy of Yang and Yin was based on the concept that, from the time of creation, there arose the dualistic forces of Yang and Yin, from which all phenomena of nature proceed. Yang was the male principle and was active and positive. The female principle, Yin, was inactive and passive. Gordon reports the Yang and Yin that controlled the phenomena of nature were heterogeneous powers, or polarities. Both of these had mutual affinities for each other and at the time they were antagonistic to one another.

In ancient Japan, 'The physiology was just as obscure as the anatomy. It was based on the concept that there existed in the body a double principle: masculine (positive) and feminine (negative)' (Gordon, 1949). Even in the Orthodox Christianity we can see the duality as Christ and Euclesia, Christ's bride, The Church (Perry, 1953).

Jung (1947), in his book *Die Psychologie der Uebertragung*, referred to a series of alchemical pictures which were taken from *Rosarium Philosophorum* (published in 1550). Investigations of these pictures caused Jung to consider that the symbol of wholeness, the Self, is the divine child resulting from the conjunction of opposites.

Mythology in relation to the changing ego states

As it was shown in the topographic study Mrs F.'s each 'side' was composed of different 'frames of mind' which, in psychological terms, we can refer to as different ego states. At times, the changes of these ego states took peculiar forms, expressed by the patient as being in a 'circle', 'twisted-up', 'reversed' and 'scrambled-up'. In relation to these changes Whilhelm & Baynes (1953) are quoted concerning the mythology of the Chinese Cosmic Pair, Yang and Yin. 'It is to be noted that although the Great Absolute is a cosmic axis uniting the contraries, the philosophy of the Yang and the Yin tells the alternations of ascendency of the one over the other in circular fashion. When Yang is at the Zenith and Yin at the lowest reach, then the seed of the Yin is born in the midst of the

Yang and that of the Yang in the midst of the Yin, which then initiates the reversal of their position.'

Multiple personality

The most detailed study of multiple personality is Prince's (1957) study of the case of Miss Beauchamp. Prince, who did not explain his case in Freudian terminology, talked about 'co-consciousness' or 'concomitant consciousness' in order to define 'the coexistant dissociated thoughts'. Prince says: 'This subconscious personality and the waking personality together represent a doubling of the mind, but this doubling exists because certain mental states have been dissociated from the main stream of consciousness and have acquired a more or less independent existence, and formed an "extra" mind.'

When Prince's patient came to see him, she was known as Miss Beauchamp and Prince hypnotized her and called the patient's trance her 'hypnotic self'. Remembering Mrs F.'s hypnotic experiences, we find it interesting to report that all of Miss Beauchamp's other 'selves' clinically appeared after she was hypnotized, although not directly after the use of hypnosis. Prince writes: 'Of course, it is manifested that one of the most marked peculiarities of Sally's [Sally is one of the personalities of Miss Beauchamp] personality is its child-like immaturity. Sally is a child. This suggested the idea that Sally might be a reversion to an early period of Miss Beauchamp's life. It is a well-known fact that in hypnotic experiments certain states may be artificially produced in which the subject is found to have reverted to a particular period of his life.'

Freud (1927), in discussing 'the ego's object identifications', wrote: 'If they obtain the upper hand and become too numerous, unduly powerful and incompatible with one another, a pathological outcome will not be far off. It may come to a disruption of the ego in consequence of the different identifications becoming cut off from one another by resistances; perhaps the secret of the cases of what is described as "multiple personality" is that different identifications seize hold of consciousness in turn. Even when things do not go so far as this, there remains the question of conflicts between the various identifications into which the ego comes apart, conflicts which cannot, after all, be described as entirely pathological.'

Bleuler (1955) wrote: 'Single emotionally charged ideas or drives attain a certain degree of autonomy so that the personality falls to pieces. Those fragments can then exist side by side and alternately dominate the main part of the personality, the conscious part of the patient. However, the patient may also become a definitely different person from a certain moment onwards.'

Federn (1955) spoke of 'hysterical identifications with oneself'. According to him, it may be possible for a person to identify himself with a past ego state.

Fenichel (1945), talking about 'isolation as a defence', writes: 'Many try to solve conflicts by isolating certain spheres of their lives from one another, such as school from home, or social life from the secrets of their loneliness; one of the two isolated spheres usually represents instinctual freedom and the other good behaviour. They even split their personality and state that they are two children with different names, a good one and a bad one, and deny the good one's responsibility for the bad one's deeds.

Whether the famous cases of "dual personality" should be called isolations or repressions depends upon whether or not the person in the state knows about the existence of the other state. These cases show that isolations and repression are basically related to each other.'

Meerlo (1960) writes that any person can experience the revelations of multiple dream personalities in his own dream life. 'These intruders into our minds sometimes make too dominant an impact on our feelings and thinking, and they may stage permanent roles in our psychic life.' This author also reminds us that 'from a structural standpoint, there

are many egos living in man, many substructures, many internalized images waging an ecological battle between instinctual invasions on the one hand and coercive persuasions on the other. This is illustrated by examples of so-called multiple personalities, depersonalization, depersonification, and mystic and psychotic selflessness.'

So far we have seen that so-called multiple personality cases were discussed in non-Freudian terminology, in regard to the ego's object identification, identifications with the past ego states, some ego defences, and structural standpoint of the ego's development. Therefore, these cases do not seem to form any clinical entity and maybe because of these they are labelled 'so-called' by many authors. So far as Mrs F.'s case is concerned, neither her general 'right' or 'left' orientation (see Table 1) nor any of her 'frames of mind', was crystallized. Crystallization is used here to express the meaning of the words as definite, completely clear and separate. In other words, the patient was changing her ego states continually, but none of these ego states was stationary.

The preoccupation with how to relate to objects and hypochondriasias

At the beginning of the schizophrenic disorder there is a regression to narcissism, and on many occasions this phase is accompanied with hypochondriacal sensations. Regression to narcissism 'brings with it an increase in the "libido tonus" of the body..., and this increase makes itself felt in the form of the hypochondrical sensations' (Fenichel, 1945). On a clinical level the hypochondriac shows 'an obsessive kind of preoccupation with physical functions and body process' (Laughlin, 1955) and this shows similarity to Mrs F.'s constant preoccupation with her psychic process. Mrs F. constantly observed the psychic changes in herself and such preoccupation did not allow her to be interested 'outside' herself. She described this as 'When I talked to you even about the weather or

music, I still wonder whether I am talking from the left or the right side. If I started talking [the patient aggressive] I am on the right side, if you started talking [the patient passive] I am on the left side.'

Mrs F.'s main preoccupation did not seem to be due to an increase in the 'libido tonus' of the body (however, the patient did have hypochondriacal sensations—bodily—but this did not gain the degree of primacy in her clinical symptomatology) but rather a hypertrophic interest of how to relate to objects. In this hypertrophic interest of how to relate to objects, like in the increase in the 'libido tonus' of the body, there is a withdrawal of interest and libido from the objects in the outer world.

In *The ego and the id*, Freud (1927) stated that the ego is primarily a bodily thing. Later, Schilder (1935) suggested that the 'body image' is the nucleus of the ego. 'The hypochondriacal sensations at the beginning of schizophrenia show that, with the regressive alteration of the ego, this nucleus appears once again and is altered' (Fenichel, 1945). If this statement is accepted, we can suggest that hypochondriacal body sensations are related to a deeper regression than the regression that is related to one's preoccupation of how to relate to objects (primary object relationship). However, both processes appear to have the same mechanism.

Changes of the ego states as a defence

Mrs F. once reported that the first time she felt something was going wrong was when she noticed that other people's statements or opinions in disagreement with her began to bother her in a particular way. To illustrate. One morning during her stay in the hospital, she was awakened by a new nurse's *aide*. The patient asked the *aide* if she had seen her before. The *aide* replied that she had previously seen the patient playing the piano. This disturbed the patient very much because on that day she had not played the piano, but she might have been singing while standing

by the piano. She reported that if this incident had happened before she became ill she might have said to the *aide* that she had not played the piano. Now, however, the *aide's* statement, due to the patient's weak or broken ego boundaries, brought doubt and she questioned whether she was really capable of recognizing reality. To escape this disturbing phenomenon she went into another 'frame of mind', which in a sense was safer. Meanwhile, the observation of this change within herself possibly kept her further away from the disturbing event which occurred 'outside' of herself. She summarized this in her own way by stating: 'The reality is where I am out of the reality.' Another time she said: 'The reality is the things around me—in the way I wish them to be.'

It is obvious that during therapy the patient would use a change of ego states, which in itself was a painful experience, and hypertrophy of self observation as defences when faced with disturbing phenomena such as painful memories, ambivalent transference, or the fear of going 'crazy'. As therapy became more successful, the patient once reported to her therapist that: 'I know you were trying to pin-point me at one place.'

Meerlo (1960) writes that disorganization of personality may happen to anybody in extreme fear or in a state of toxication, and it can be a defensive avoidance reaction. According to Weiss (1955): 'When there is a deficiency of ego cathexis, a highly developed and organized ego cannot maintain adequate cathexis of all its boundaries, and it is therefore exposed to invasion by the unegotized unconscious. In such a case, regression to an earlier ego state, requiring less expenditure of ego cathexis, can be used as a defence against false realities.'

Two reported cases with similar symptomatology

Scott (1951) reported the case of a psychotic woman 45 years old, whose symptoms showed an extreme similarity to some of Mrs F.'s symptoms. For example, among other symptoms, Scott's patient, whose body felt 'as if it was identified with the earth' described a vertical split through her body. Scott wrote that 'She is the sleeping, unconscious woman felt on the left. On the other hand, we have the right side of her head which contained the conscious aspiring will. This right side possessed by the spirit of the father above, the masculine spirit which Jung calls "the animus".' In Scott's case 'the unconscious is to the left—to the right is the conscious; the left, femine, the right, masculine'. Scott's patient was always bumping into things on the left. 'Corresponding to the unconsciousness of the left side of the body there was also something wrong with the left side of the space.' The left and the right 'were compensatory opposites, one balanced the other, so that when the right went up the left went down, but they did not fit together'.

Abse (1955) reported the case of another young woman who was diagnosed as paranoid schizophrenic. This patient complained that her soul was trying to hold her body together with difficulty. But there were many souls. Some souls were against her, whereas other nice souls struggled against those which opposed her. Among other specific symptoms Abse's patient discussed the feeling that she had left parts of herself all along the way from New York to California.

While Scott examined his case with a Jungian approach Abse referred to Edward Glover's conceptual model of the historical modifications of ego-structure—the primitive ego is polynuclear in the sense of a series of independent organizations and these organizations become more coherent and integrated as the anal-sadistic level of libido organization is reached. Abse states that his patient was communicating her perception of a disintegrating personality process and that 'decomposition products of schizophrenic psychosis reveal the operation of primitive ego-nuclei postulated as normally occurring during the early course of individual development'.

Regarding the dynamic mechanism of what can be referred to as 'the hypertrophy of self observation', Abse (1955) reports that psychoanalytic theory has identified the super-ego with an inwardly-directed, scrutinizing function. In his patient: 'It is clear that ego-feeling has become largely invested in the super-ego as part of the total defensive operation. The patient strives to identify herself with the super-ego fraction of her total personality, and to a very large extent, one might say to a pathological extent, she succeeds. It is this achievement which enables us to share her scrutiny of what goes on within, for in her own way she formulates and communicates this scrutiny.' (Abse, 1955.)

SUMMARY

As Fenichel (1945) indicated the psychoses are, of course, not the only states where regressions of the ego are observable. However, 'the investigation of psychotics with their regression to primitive ego phases greatly increases the knowledge of these earliest stages'. This paper deals with the case history and observation of the changing ego states of a schizophrenic woman. Some of the observed ego states of this patient are thought to be primitive. The patient had an obsessive kind of preoccupation with the psychic changes within herself and talked about them.

The patient's changing ego states followed peculiar patterns which were shown topographically by drawings. She expressed these patterns with different 'frames of mind' which were either on 'the left' or on 'the right'. This paper suggests that the symbols of 'the left' and 'the right' which are related to a duality in the psychic structure, and the peculiarity of changing ego states can be examined from different angles. To see an object from different points of view does not necessarily complicate the issue, but can help the object to appear clearer.

REFERENCES

ABSE, D. W. (1955). Early phases of ego-structure adumbrated in the regressive ego state of schizophrenic psychosis, and elucidated in intensive psychotherapy. *Psychoanal. Rev.* **42**, 288–37.

BENEDICT, L. (1916). A study of Bagobo ceremonial, magic, and myth. *Ann. N.Y. Acad. Sci.* **24**, 1.

BLEULER, E. (1955). *Dementia Praecox or Group of Schizophrenias* (tr. by J. Zinkin), pp. 144–7, 298. New York–London: Int. Universities Press.

EDINGER, E. (1955). Archetypal patterns in schizophrenia. *Amer. J. Psychiat.* **112**, 354–7.

FEDERN, P. (1955). *Ego Psychology and Psychosis.* New York: Basic Books.

FENICHEL, O. (1945). *The Psychoanalytic Theory of Neurosis.* New York: W. W. Norton.

FERENCZI, S. (1945). Cited by O. Fenichel in *The Psychoanalytic Theory of Neurosis*, p. 224. New York: W. W. Norton.

FRAZER, J. (1953). Cited by J. W. Perry in *The Self in Psychotic Process*. Berkeley–Los Angeles: University of California Press.

FREUD, S. (1927). *The Ego and the Id.* London: Hogarth and Inst. Psychoanal.

GORDON, B. L. (1949). *Medicine Throughout Antiquity*, pp. 357, 396. Philadelphia: F. A. Davis Co.

GUTHEIL, E. A. (1960). *The Handbook of Dream Analysis*, pp. 245–6. New York: Grove Press.

JUNG, C. G. (1947). *Die Psychologie der Uebertragung*. Zurich: Raschler.

LAUGHLIN, H. P. (editor) (1955). *A Psychiatric Glossary.* Washington: Amer. Psychiat. Ass.

MEERLO, J. A. M. (1960). 'Who are these: I, me, ego, and myself'. *Psychoanal. and Psychoanal. Rev.* **47**, 83–96.

PERRY, J. W. (1953). *The Self in Psychotic Process.* Berkeley–Los Angeles: University of California Press.

PRINCE, M. (1957). *A Dissociation of Personality.* New York–London–Toronto: Longman's Green.

SCHILDER, P. (1935). *The Image and Appearance of the Human Body.* London: Paul, Trench, Trubner.

SCOTT, R. D. (1951). The psychology of the body image. *Brit. J. Med. Psychol.* **24**, 254–66.

SEARLES, H. F. (1961). Sexual process in schizo-phrenia. *Psychiatry* (Chestnut Lodge Sympo-sium Issue), **24**, 87–95.

STAERCKE, A. (1914). Rechts und Links in der Wahnidee. *Int. Z. Psychoan.* **2**.

STEKEL, W. (1911). *Die Sprache des Traumes.* Wiesbaden: Bergmann.

WEISS, E. (1955). Introduction in *Ego Psychology and Psychosis* by P. Federn, pp. 1–21. New York: Basic Books.

WHITEHORN, J. C. (1953). Psychodynamic ap-proach to the study of psychosis in *Dynamic Psychiatry*, by F. Alexander and H. Ross, pp. 255–84. Chicago: University of Chicago Press.

WHILHELM & BAYNES (1953). *The I Ching or Book of Changes*, Vol. I. Reported in *The Self in Psychotic Process*, by J. W. Perry. Berkeley–Los Angeles: University of California Press.

ZIMMER, H. (1946). *Myth and Symbols of Indian Art and Civilization*, Bollingen Series 6. New York: Pantheon.

Some ego aspects of alcoholism

By GENE H. BOROWITZ*

Many possible routes of exploration are open to the psychiatric investigator who studies alcoholism—genetic, dynamic, structural, and adaptational factors all are important. In this paper, a specific aspect of this common and complex disorder has been selected for examination: the nature of the changes that alcohol brings about in the ego. Some of the implications of this altered ego state will be considered as they relate to previously stated concepts of alcoholism.

A brief mention should be made of selections from the literature that are relevant to the themes presented here. Freud (1930), Abraham (1927) and Ferenczi (1916, 1926) pointed out that alcohol decreases repression and permits a freer expression of infantile cravings, notably those of oral dependency and latent homosexuality. Rado (1926, 1933), Knight (1937 *a, b*) and Simmel (1948) focused upon regression to oral erotism. Rado postulated that during childhood the alcoholic was uncertain of oral gratification, and that this uncertainty results in extreme intolerance to frustration in the adult, in whom inevitable frustration leads to a 'tense depression'. He said that it was in this state of tense depression that the individual was particularly susceptible to the 'elating effects' of alcohol. Knight stressed that the underlying oral fixation could be manifested in a variety of emotional conflicts and that alcoholism should be viewed as a symptom rather than a syndrome. Simmel focused upon the vicissitudes of oral aggression and their manifestations. All three authors emphasized the importance of depression, and Simmel stated

that alcoholism served as a defence against depression. Higgins (1953) viewed alcoholism from a point of view of ego psychology. He stressed the adaptational aspect of alcoholism and the psychosexual non-specificity of the underlying conflicts. He emphasized a two-phase sequence in alcoholism; as alcoholism progresses, the 'original psychodynamic conflict which was the etiologic base becomes less obvious and the "oral narcissistic elements" more obvious'.

CLINICAL MATERIAL

The patient, a 30-year-old housewife and mother of two daughters, ages six and three, sought treatment for her inability to control her drinking, which had become a problem for the second time after her first daughter's third birthday, which occurred one month after the birth of her second child. She had increasing difficulty with drinking and made a suicide attempt shortly before seeking therapy. She complained of symptoms of severe depression and said that she drank to ease these feelings.

The patient was the only child of parents who were described as alcoholics. Her mother died, presumably a suicide, on the patient's third birthday. She was brought up in a succession of homes by her paternal relatives. Her father lived with another woman in a common-law marriage and had a son in this marriage. Although the patient frequently saw her father, she never lived with him.

Her paternal grandmother, with whom she lived on several occasions, would tell the patient stories about her mother whenever she got angry at her: 'You will grow up to be just like your mother, a drunken no good tramp.' She remembered being a sad and frightened child who was considered a 'stupid ugly duckling'.

The patient described her father, with a good deal of anger, as a 'no-good drunken bum' who finally died on skid row. She was furious at him for never having taken care of her.

The patient had become rebellious when an adolescent, had disciplinary problems in school, and quit high school at the end of her freshman year. On several occasions she ran away from home, found she had no place to go, and sheepishly returned.

She worked steadily from the time she left school until she was married at age 20. She felt that her husband married her because he was sorry for her, but she was grateful for the opportunity of getting away from home. Her husband was in the armed forces at the time and after a fairly happy year he was transferred overseas for about one year. During this time the patient felt abandoned and would frequently get drunk to ease the feelings of loneliness. At this time she began to seek out men in bars when she was slightly intoxicated. This would usually lead to non-gratifying intercourse and be followed by feelings of intense rage and guilt, and more drinking.

She became pregnant when her husband returned and, after some initial anxiety, was quite pleased with the prospect of having someone to ease her loneliness. The pregnancy and delivery were uneventful but following her daughter's birth she suffered from feelings of uselessness and hopelessness, feeling she would never be able to care for or raise the child properly. These feelings lasted for several months and then abated.

She described a fairly happy existence living with her husband and daughter and she seemed to function well.

She became pregnant again, and delivered another girl shortly before her first daughter's third birthday. She became markedly depressed and began to drink heavily. She found that drinking decreased the intensity of her feelings of depression.

About five months after the birth of her second daughter, her husband was again transferred overseas. Her depression and drinking increased. She and her children joined her husband overseas but her severe depression continued. While overseas, she attempted suicide with an overdose of barbiturates following a drinking episode. (She was 27 years old at this time, the same age as her mother at her time of death.) She was hospitalized, received psychiatric care, and was discharged improved.

From this time the patient drank quite consistently. When separated from her husband she would, after becoming mildly intoxicated at home, go to a bar, seek out men and repeat the pattern described earlier.

The patient made another suicide attempt following her second daughter's third birthday, all third birthdays being extremely significant to her. It was the feelings that led up to and followed this suicide attempt that brought her into treatment with me.

I would like to present segments of two therapy sessions to which the patient came intoxicated. The characteristic feature of both sessions was that at the onset of the session, while clearly intoxicated, the patient was calm and composed and able to talk about traumatic material with little affect. As her intoxication decreased, she experienced increasing amounts of distressing affect accompanied by signs of ego fragmentation, which eventually reached panic proportions.

The first of these sessions followed several in which the patient had raged about her drunken father and how he had abandoned her and never cared for her. At the same time she was furious with me for not taking care of her adequately and for not telling her what to do. She came in to the hour quietly, as opposed to her usual grumpy, attacking demeanour, and stated that she felt guilty because she had picked up a man the previous night. She calmly described how it was necessary for her to seduce the man and to give him great sexual pleasure, pretending to be very excited herself, while all the time she was unmoved. She felt that she was drunk when she started the seduction but became sober as soon as the man had achieved orgasm. She then felt that she hated him and wanted to destroy him. She left him and felt disgusted with herself and had to drink herself to sleep. (The same pattern was followed in all such episodes.) She spoke of how she was afraid to tell me her 'sins' and therefor drank before she came to the hour. When reminded that for the past several hours she had railed against her father, she remembered, how, as a small girl, she used to enjoy going into the neighbourhood bar where her father was ensconced. She remembered how pleasant he was when 'half drunk' and how he played with her, cuddled her, and boasted to all his friends about his delightful little daughter. As the hour progressed her calmness gave way to agitation; she became markedly depressed and wished for the good times with her father in the tavern. She

railed at herself for her lack of devotion to her husband and children and complained bitterly that the only way to end her suffering was to kill herself. She screamed at me for not telling her what to do and yelled that I was just like her father who didn't have enough time for her. By this time the patient appeared completely sober. She said she was completely sober and that she couldn't stand it. She felt she'd either have to drink or kill herself. Then she began to talk about her daily schedule with her daughters and repeated several interpretations about loneliness that I had given her over the preceding weeks. She left the hour still agitated and depressed.

The second session followed several in which the patient had spoken about her mother. She said that she remembered nothing of her mother, but that all the stories depicted her as alcoholic, promiscuous, and generally irresponsible. She commented on how everyone's (particularly her paternal grandmother's) predictions that she would turn out just like her mother 'had come true'. She came into the office telling me belligerently that she was drunk because I wouldn't help her. She said that I wouldn't tell her how to be a good mother, that her children got on her nerves, and that she got so angry at them at times that she would go after them with a broomstick. She complained about her loneliness and expressed fear of people breaking into her apartment. She spoke of her disgust with herself and how she felt she ought to kill herself. I commented that she seemed to 'want to turn out just like her mother'. She commented that she wasn't sure her mother killed herself. I asked about the circumstances, whether the suicide had been by taking sleeping pills and she said no. During the early part of the hour she painted a fairly clear picture of her memories of her mother's death. She said it had been right after her birthday party. She had been very happy. Her mother had been a little drunk but happy, then had complained of a headache and had gone to the bathroom for some medication. When she came out she was retching and spitting blood and had fainted. An ambulance was called and her mother was taken away. She died the next day. It was discovered that her mother had taken lye 'by mistake'. The patient began to feel increasing agitation as she told the story. She cried because she felt she might have been at fault by making too much noise and thus causing her mother's headache. She felt guilty

for being angry at her mother for abandoning her and ashamed of herself for all the bad things she had done in her life. She recalled the picture of her mother lying on the floor and said that it was printed on her mind and that she can't tolerate seeing it. As the session progressed her agitation increased and her inebriation decreased. She screamed at me for not helping her: 'Why won't you give me medicine?' She told me that drinking 'makes the picture not seem so bad'. She said that most of the time she is not aware of the picture but when it does come into her awareness she feels she has to kill herself to make it go away. I attempted to have the patient focus her feelings upon me and she spent the rest of the hour alternating between telling me I was no good and fearing that I would not continue to see her. By the end of the hour she remarked that she was completely sober and didn't like it. Three days later she made an attempt at suicide by shooting herself in the abdomen. She was coming out of a drunk, felt she might be pregnant and decided to see what it would feel like to shoot herself. She perforated the descending colon, just missing the uterus. She made an uneventful recovery and returned to therapy.

DISCUSSION

Although the clinical material presents many fascinating areas for discussion, only the patient's problems with alcohol will be considered here.

She began to have difficulty controlling her drinking when, a year after their marriage, her husband was transferred overseas. She felt abandoned, became depressed and found that drinking eased her feelings of loneliness. Although she began drinking at home alone, after a certain state of intoxication was reached, she would go to a bar and pick up a man. While being unfaithful to her husband, who had deserted her, she was re-enacting the childhood experience of seeking her father, who had deserted her, in a bar. The oedipal aspects of this material are obvious, and need not be further elaborated in this paper.

The patient, when 'abandoned', felt helpless and the helplessness was accompanied by

intense rage. She was overwhelmed with hatred and self-hatred and wanted her father to 'rescue' her. Because of his rejecting behaviour her wish was never gratified, and further, since it was a megalomanic expectation, it was bound to meet with failure. In adulthood her promiscuity represented her continuing vain attempt to gratify these infantile needs. After each episode, she found the ensuing rage intolerable and would begin to drink again.

She became depressed and began to drink heavily again during the period that encompassed her first daughter's third birthday and the birth of her second child. This seems to be an example of Simmel's (1948) thesis that alcoholism functions as a defence against depression. The material is also a clear example of the phenomenon of the anniversary reaction described by Hilgard & Newman (1959). The patient had severe difficulties following the third birthdays of each of her daughters, she was three when her mother died, and she made a suicide attempt when she was the same age as her mother had been when she died. However, unlike Hilgard's cases, my patient did not suffer from a schizophrenic episode.

Although she clearly demonstrated both depression and anniversary reaction, I do not think that either fully explains her alcoholism. My hypothesis is that alcohol brought about an ego state in which the patient's perception of her underlying rage was modified. I believe that if it is not modified, intense underlying rage leads to progressive stages of ego fragmentation that take the form of depression, paranoia, or schizophrenic episodes.

The basic psychological effect of alcohol appears to be a modification of the ego in which there is decreased sharpness of perception so that an ego state occurs in which disturbing affect is dulled. During this state of partial anaesthesia, the ego, which had been disrupted by overwhelming affect, is able partially to reinstitute defences and to achieve a level of moderately stable integration.

It was possible to observe this process clinically on the several occasions when the patient was drunk when she arrived for her appointment. That conflicts involved in the therapeutic relationship contributed to her drinking at such times is clear. The sessions were characterized by the patient recalling ego-alien material, which had been repressed previously, with virtually complete lack of affect. Concomitant with signs of decreasing intoxication, the patient dealt with the now-conscious ego-alien material and experienced increasing amounts of disturbing affect, and finally reached a state of panic. Signs of ego fragmentation became manifest; paranoid ideation was prominent and the patient's reality testing became tenuous. She pleaded for a drink or to be allowed to kill herself, saying that what she was experiencing was intolerable.

The changes in ego integration that are frequently seen when alcohol is forcibly withdrawn from an alcoholic illustrate the thesis that alcohol helps to achieve a defensive equilibrium characterized by an ego state relatively free of disruptive affect. Those who deal with alcoholics are well aware of the frequency with which suicide, psychosis, or a psychosomatic illness are precipitated by the withdrawal of alcohol. There is a group of alcoholics in whom symptoms of peptic ulcer are present only when alcohol is withdrawn. These people frequently haemorrhage or perforate when hospitalized for treatment of alcoholism. Several have left the hospital in the throes of a severe ulcer attack and begun to drink and by doing so were able to abort the attack. It seems apparent that the well-known adverse local pharmacologic effects of alcohol may be significantly over-shadowed by the altered ego state that it produces. Chessick, Looff & Price (1961) have discussed the occurrence of peptic ulcer in alcoholic-narcotic addicts and focused upon the vicissitudes of rage. Giovacchini (1959) has discussed psychosomatic disorders from the point of view of varying states of ego integration, a concept that seems highly applicable

to cases in which somatic symptoms and alcoholism alternate.

The concept of an altered ego state induced by alcohol helps us to understand 'compulsive' drinking. An alcoholic is often defined as a person who cannot stop drinking once he starts; he feels 'compelled' to continue drinking. The first effect of the alcohol is to decrease the acuity of the ego's perceptions. Concomitant with this altered ego state is a lowering of the repressive barrier. Freud (1930) and Ferencz (1916, 1926) have commented that alcohol leads to a decrease in repression and permits a freer expression of ego-alien impulses. I believe that the lowering of the repressive barrier by alcohol follows and is dependent on the decrease in the sharpness of the ego's perceptions. The lowering of the repressive barrier permits ego-alien material to find its way into consciousness. This ego-alien material is not experienced as severely disturbing (affectively) until the effect of the alcohol diminishes, when the ego-alien material remains in consciousness. The ego, now unprotected by the effects of the alcohol, experiences the painful affect associated with the ego-alien material. This pain brings into being the need for another drink and the vicious cycle has begun.

There have been frequent comments regarding changes in the superego following the ingestion of alcohol. Phrases such as 'freer expression of infantile cravings' and 'decrease of inhibitions' reflect superego alterations. The superego has been facetiously defined as that part of the psychic apparatus most soluble in alcohol.

Sandler (1960), in his discussion of the superego, suggests that drugs, including alcohol, produce a 'feeling of well being in the self' thus providing sufficient narcissistic gratification so that the ego may disregard the dictates of the superego. This formulation appears to be at variance with my clinical observations regarding the alcoholic's feeling-state during intoxication. Alcoholics rarely describe a 'feeling of well being in the self when intoxicated'. Rather they state, 'It's not that I feel good when I'm drunk, it's just that I don't feel so bad'.

Superego demands are effective so long as they are affectively experienced by the ego. As stated earlier, the basic psychological effect of alcohol appears to be a decrease in the acuity of the ego's perceptions, which dulls disturbing affect. When intoxicated, the alcoholic continues to experience the intellectual content of superego dictates although its affective component is paralysed. When this state has been achieved, the ego may disregard the precepts and demands of the superego.

The alcohol-induced alteration of ego-superego interaction helps to explain the emergence of previously repressed ego-alien material. Sandler (1960) in considering this states: 'In psychotherapy or in analysis, the supporting role of the analyst, who may be invested with the authority of the parents, can permit the ego's dependence on its superego to be sufficiently reduced to enable forbidden and repressed material to be brought into consciousness....' Whenever superego demands are not perceived with their affective component, repressed material will come into consciousness. The difference between the therapeutic and alcoholic situations lies in the different states of ego integration, primarily in regard to external objects, which characterize them. In the therapeutic situation the superego is modified through the use of an external object; in the alcoholic state, these changes occur narcissistically, *only* concerning internal objects.

The ingestion of alcohol decreases the acuity of the ego's perceptions not only, or primarily, of the external world but, far more important, of the other psychic institutions.

One of the points I wish to emphasize is that of the alcoholic's vulnerable ego. The alcoholic is one whose defences are not adequate to cope with certain conflict situations. My patient demonstrated this when she felt abandoned, was overwhelmed with feelings of being unacceptable, and subsequently experienced feelings of omnipotent destructiveness. Her defences became overwhelmed and

ego fragmentation occurred. It is at these times that my patient began to drink.

The difference between an alcoholic and a non-alcoholic appears to be the ability to mobilize ego defence mechanisms in the face of conflict after the effect of alcohol wears off. The non-alcoholic re-establishes equilibrium by reinstituting his defences. The alcoholic has too few defences. He needs to drink until he can achieve reintegration.

Reintegration is achieved by a variety of means. At some times sleep will be effective, but frequently the alcoholic can't 'sleep it off'. He awakens to find the painful ego-alien impulses still in consciousness and needs a 'morning drink'. It is interesting to note that many alcoholic patients claim that they never dream in a drunken sleep. Reintegration is sometimes achieved after 'total ego anaesthesia' with massive rapid ingestion of alcohol, and other times it is achieved only after the C.N.S. dysfunction that accompanies D.T.'s. There is great variability in the availability of defensive reintegration at different phases in an alcoholic's life. The variation depends upon the degree of conflict and the strength of available defences at a particular time.

A disturbance in ego development is fundamental to the concept of alcoholism elaborated here. Kohut (1959) has stated that addicts rely on drugs not as a substitute for object relations but as a substitute for psychic structure. I think the same holds true for alcoholics. This lack of psychic structure results from the serious disturbances in early object relationships which characterize the lives of alcoholics. These disturbances result from inadequate maternal care either because of actual loss or because of emotional unavailability. The impact of the disturbed mother-child relationship is aggravated by the inability of the family (or social group) to provide the child with adequate substitutes.

Knight (1937a, b) found the early development of his alcoholic patients characterized by maternal overindulgence. He felt the mother's overindulgence was frequently an expression of and defence against her hostility to the child. He emphasized that the mothers in his cases discouraged any autonomy and that as a result the patients remained fixated at a rather primitive level. He also commented upon 'the unavailable father' in most of his cases. In his group of patients, conflicts centring about autonomy most frequently led to the excessive use of alcohol.

The patient discussed in this paper could in no way be considered overindulged. Her mother died when she was three, her father 'deserted her', and she was raised in a succession of foster homes. Rather than overindulged, she was deprived. This patient's early life history is in no way unique. Alcoholics with lower class backgrounds present a high incidence of early parent loss and subsequent family disorganization.

Inadequate maternal care, whether through actual loss or inappropriate need gratification is constant theme in the early life of the alcoholic, and I believe it is the factor that distorts early ego development.

The incidence of an alcoholic parent (or parents) in the families of alcoholics is high (Ellermann, 1948; Harper & Hickson, 1951; Moore & Ramseur, 1960). In the present case the mother is said to have been alcoholic and the father was a known alcoholic. Alcoholism in a parent is a major and adverse influence in the early development of a child's ego not only because such parents are emotionally unavailable, but also because parents are the objects most available for identification. Winnicott (1958) has suggested that disturbed early object relationship leads to premature and exaggerated utilization of objects for identification. Less deprived children are freer in their 'choices'. A developing child has transmitted to it not only the parents' conflicts, but frequently the parents' defences against these conflicts. In the case of alcoholics, it is suggested that a parent had particular conflict areas in which he or she used alcohol because other ego defences were inadequate; when the child experiences similar conflicts, he may deal with them in accordance

with the model provided by the parent. Any form of deprivation intensifies the child's identification with the parent's defective defensive system. Thus, the stage is partially set for the later development of alcoholism.

SUMMARY

Some ego aspects of alcoholism are considered in regard to a patient who had had a deprived childhood and who became alcoholic after separation from her husband. The hypothesis is proposed that the basic psychological effect of alcohol is a modification of the ego involving a decrease in the acuity of perception. The alcoholic is defined as an individual who, because of inadequate maternal care resulting either from actual loss or from inappropriate need gratification, has areas of ego maldevelopment and upon whom the effect of alcohol is to dull disruptive affect, permitting the ego to reinstitute shattered defences and achieve a moderately stable level of integration. Various aspects of alcoholism including 'compulsive drinking', ego-superego interactions, and early identifications are considered in relation to these hypotheses.

REFERENCES

ABRAHAM, K. (1927). The psychological relations between sexuality and alcoholism. In *Selected Papers*, ch. 3. London: Hogarth.

CHESSICK, R. D., LOOFF, D. H. & PRICE, H. G. (1961). The alcoholic-narcotic addicts. *Quart. J. Stud. Alc.* **22**, 261.

ELLERMANN, M. (1948). Social and clinical features of chronic alcoholics. *J. Nerv. Ment. Dis.* **107**, 556.

FERENCZI, S. (1916). On the part played by homosexuality in the pathogenesis of paranoia. In *Contributions to Psychoanalysis*. Boston: Badger.

FERENCZI, S. (1926). *Further Contributions to the Theory and Technique of Psychoanalysis*, pp. 113, 245. London: Hogarth.

FREUD, S. (1930). Three contributions to the theory of sex. *Nervous and Mental Dis. Mon.* 4th ed., pp. 43, 74.

GIOVACCHINI, P. (1959). The ego and the psychosomatic state. *Psychosomat. Med.* **21**, 218.

HARPER, J. & HICKSON, B. (1951). Results of hospitalized treatment of chronic alcoholics. *Lancet*, ii, 1057.

HIGGINS, J. W. (1953). Psychodynamics in the excessive drinking of alcohol. *Arch. Neurol. Psychiat.*, Chicago, **69**, 713.

HILGARD, J. R. & NEWMAN, M. F. (1959). Anniversaries in mental illness. *Psychiatry*, **22**, 113.

KNIGHT, R. P. (1937*a*). The dynamics and treatment of chronic alcohol addiction. *Bull. Menninger Clin.* **1**, 233.

KNIGHT, R. P. (1937*b*). The psychodynamics of chronic alcoholism. *J. Nerv. Ment. Dis.* **86**, 538.

KOHUT, H. (1959). Introspection, empathy and psychoanalysis. *J. Amer. Psychoanal. Ass.* **7**, 459.

MOORE, R. A. & RAMSEUR, F. (1960). A study of the background of 100 hospitalized veterans with alcoholism. *Quart. J. Stud. Alcohol.* **21**, 51.

RADO, S. (1926). The psychic effects of intoxicants: an attempt to evolve a psychoanalytic theory of morbid cravings. *Int. J. Psychoanal.* **7**, 396.

RADO, S. (1933). The psychoanalysis of pharmacothymia (drug addiction). *Psychoanalyt. Quart.* **2**, 1.

SANDLER, J. (1960). On the concept of superego. *Psychoanalytic Study of the Child*, **15**, 128.

SIMMEL, E. (1948). Alcoholism and addiction. *Psychoanal. Quart.* **17**, 6.

WINNICOTT, D. W. (1958). The capacity to be alone. *Int. J. Psychoanal.* **39**, 416.

Recovery of patients during periods of supposed neglect

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INTRODUCTION

It is considered self-evident in psychiatric treatment that 'something must be done' in order to effect a cure or relieve symptoms in the mentally ill. It is perhaps also evident that, throughout the years, psychiatric patients have been neglected or left alone, and that this situation usually evokes a negative reaction in both professional people and the laity. However, our personal experience and some of the psychiatric literature lead to the idea that some patients are best left alone at one time or another and that this seemingly paradoxical stance has a therapeutic effect. The intent of this paper is to try to define what kind of patients benefit from this experience and what is the nature of this phenomenon. We shall consider as a working definition of this: 'That situation wherein the patient is ignored or not intruded upon with resulting positive effect.' It should be pointed out that neglect in this sense is not the same as negligence. We are by no means advocating a policy of not treating patients or attempting to rationalize the non-treatment of patients. Rather we have observed a phenomenon and the observation is shared by other psychiatrists and seems to need delineation and explanation. This might be a contribution to a better understanding of spontaneous remissions of some psychiatric patients (Eysenck, 1963).

The following are the reports of six cases which illustrate the possible therapeutic results of leaving the patient alone. They are derived from our personal records and from those of professional colleagues.

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CASE REPORTS

Case no. 1

A 21-year-old single male was first seen by a psychiatrist at the age of 10 with the diagnosis of 'multiple tics and to sion spasm; Psychotic Reaction'. He was firstborn, with 'normal development' until age 2½. At that time, the family was living in a one-and-a-half room apartment with constant fear of eviction. He was noted to be extremely restless and was punished by being made to sit silently in a chair for creating any disturbance. A sister was born when the patient was 3. At age 5½ the family moved, his father had surgery, and his grandfather died. The patient began school and was extremely nervous with eye tics beginning at age 6, and tics spreading to his extremities and entire body by age 10. His tic-like behaviour disappeared when, at age 7–8, he visited his aunt's farm, only to recur when he returned home. His school adjustment was poor and his I.Q. decreased from 84 at age 7 to 64 at age 11. A Rorschach test administered then stated that he was schizophrenic.

The patient's mother was described as nebulous, cloudlike, unclear and contradictory. She rarely stopped talking to or criticizing the patient. The father was soft-spoken, passive and ineffectual. The patient was hospitalized for one year at age 10 with some improvement. The therapy was designed to help the patient to handle the threatening stimuli with the aid of a benign masculine protector. He was rehospitalized at age 13 in a state of severe disorganization. It was felt that the stress of school was too severe for him, and after some months of in-patient care he was sent to a residential treatment centre. He had occasional visual hallucinations and a variety of disturbing thoughts of a violent and aggressive content. His body movements were well controlled. His placement was an unsuccessful one characterized by the house-parents constantly being concerned about him. It was felt he could not be alone since he might break things. He was

constantly under surveillance. At age 17 he was sent to a state hospital. He continued in psychotherapy with the same therapist from age 13 to the present time. Shortly after his residence in the state hospital, he began to be more relaxed, and what had been a gradual improvement in terms of behaviour and general comfort seemed to accelerate. He eventually effected a recovery in so far as his psychosis was no longer evident, and he has done well until the present time. The patient's stay in the state hospital was noteworthy in that, except for weekly visits to his therapist, he was virtually left alone with little surveillance or concern. This state hospital was an overcrowded one and the patient was free to leave the ward and wander about at will. His parents rarely visited though he was in contact with them.

Case no. 2

A 15-year-old high-school junior was admitted to hospital complaining that he 'could not feel deeply'. He had school problems of inattentiveness, not working to capacity, and truancy since sixth grade; and family problems of passive rebellion, withdrawal, and wanting to be left alone since entering his teens. There had been episodes of self-mutilation by slashing his arms.

He was the second of three boys, born 7 years after an older brother, and following five spontaneous abortions. From the time the patient was born until age 6, the family moved repeatedly because of father's military service and his later work as a mathematics professor. When the patient was 15 months old, a brother was born. During this period he got little attention from his vague, disorganized, inconsistent mother, and erratic attention from his ambivalent father. He was described as a bright, independent child and his work in school was occasionally brilliant. He later complained to his therapist during latency and adolescence, of the intrusive quality of his parents. One year prior to hospital admission, he attended a residential school in the East with continued disciplinary infractions. Once when frightened and thinking of slashing himself, he ran out into the nearby woods at night, and felt at peace as he looked back at the lights of the school.

Psychological testing on admission indicated a verbal I.Q. of 141 and a performance I.Q. of 94. There was evidence of brilliant but bizarre thinking, with needs to retreat to feelings of tranquility and peace, and deterioration of thinking with threatened breakdown of reality. The diagnosis was of a threatened schizophrenic reaction. While in the hospital he was treated with psychotherapy, to which he gave vague lip service and kept uncommitted. He was discharged after 6 months with little improvement. He returned home, frequently missed appointments in therapy, and stated that he remained passive in the hope that something would happen. He continued to complain of having no privacy and after slashing his arms was rehospitalized two months after discharge. He was sent to a state hospital and given the opportunity to see his therapist. He was uncommitted in any programme at the state hospital, wandered about the hospital grounds and nearby neighbourhood. He rarely kept appointments. He received no treatment at the hospital and soon stopped seeing his therapist. After approximately one year, he called his therapist, stating that he had needed to view his problem from 'an Olympian position—to see my illness in perspective'. He was much improved and resumed treatment, returned to school, and eventually left the hospital.

Case no. 3

A 30-year-old housewife was admitted to hospital because of increasing violent outbursts toward her husband, 6-year-old daughter, and 4-year-old son. For 3 years prior to admission her compulsive cleaning of the children and her bathroom rituals had increased to a degree that prevented almost any other activity. She had few friends and found it difficult to accept help from anyone.

She was the elder of two children, and it was assumed from the father's description that her mother was depressed with each birth. Her sister was born when the patient was 2 years old and was favoured by the mother. The father, a successful executive, favoured the patient, and was described as a meticulous person. The mother was described as sloppy and easily upset. When the patient was 3 years old, her mother and father became ill, and she and her sister lived with their maternal grandparents. When she was 10 years old, the patient broke her arm and kept it a secret for some months.

On admission to hospital she was somewhat irrelevant, with sudden outbursts of laughter and

flattened affect. The diagnosis was that of a borderline character disorder. The treatment plan was intensive psychotherapy. The staff found it difficult not to intrude into the patient's life, and she complained about their intrusiveness. She was upset that she 'could not tell exactly what I want—get things exactly as I want them'. She was unable to get involved in therapy, but on one occasion was in her washroom and screamed obscenities at her therapist through the closed door.

After 1 year she was not improved. She was sent to a nearby hospital with strong emphasis on milieu therapy. A total push programme was instituted and her rituals increased. After 6 months she was transferred to a more custodial state hospital. After being ignored for 1 year, she left the hospital and now functions adequately with her family.

Case no. 4

A 30-year-old divorced woman was admitted to hospital because of anorexia, malnutrition, and fear of the sounds of airplanes. She subsequently deteriorated and required tube feeding. She was haughty, demanding and negativistic. This behaviour increased with the staff's permissive attitude. After 1 month she was sent to the County Mental Receiving Ward, where her symptoms disappeared and she was discharged and did well for a year.

The patient was from England, had fearlessly lived through the 'blitz', and had made a bad marriage, which subsequently ended.

One year after the above discharge, she saw an internist for physical problems. Her response to his interest and attentiveness was to become anorexic and she was eventually transferred from the medical to the psychiatric ward. After some time she was transferred to a state hospital where the therapist recognized she could accept nothing and helped her by being tough but available. She improved and was discharged and has been employed ever since. She calls her therapist from time to time with the statement 'I don't know why I called you', and he replies, 'It probably doesn't help much to talk to me, but what's on your mind?'

Case no. 5

A 45-year-old married mother of four had a series of psychiatric hospital admissions for symptoms of severe depression with addiction. She was noted to be a pathological liar in regard to her drug intake and her fictitious stories of helping other people.

The patient was one of two children, and following the death of her elder brother, she became her father's favourite with much expected of her. Her parents were described by her husband as dominant, manipulative and intrusive. Her mother was admitted to a state hospital with cerebral arteriosclerosis and, after a long stay, died there. The patient virtually ignored the mother during her hospitalization but became depressed when she died. The depression became severe and was coupled with addiction and lying when her son married against her will and broke off all relations with her.

Treatment during the patient's hospital stays was unsuccessful and usually ended with the family forgiving her for her behaviour and taking her home. She was usually readmitted shortly afterwards when the family became angry and abusive. She was finally sent to the same state hospital that her mother had been in. She had no treatment there but shortly recovered and returned home, and has maintained her recovery.

Case no. 6

A 44-year-old housewife entered the hospital after becoming uncontrollably abusive to a woman in the neighbourhood whose dog had attacked her. The patient had become hyperactive, sleepless and ill-tempered for some weeks following the death of her dog. She felt her ties with the household had been broken with its death. She was one of heterozygous twins, and had spent her first 3 years in a children's home with her brother, as foundlings. There is no record of the parents. From ages 3–8 years they were in a foster home and following this returned to the children's home. They were placed in a series of unsatisfactory foster homes until age 13, when they were placed in a stable home and remained there until age 18.

The patient was married and divorced twice from ages 18 to 21, and was close to no one except her brother. He married but died soon afterwards of unknown causes. The patient was grief-stricken and said she decided she could not trust human beings. She married once again at age 30, but after four years of marriage her husband found her a burden. She felt she could

only trust God, and for the past 10 years has been intensely religious.

During her hospitalization, the patient was agitated, angry, impatient and demanding. She seemed unapproachable and became more agitated with contact. Periods of agitation were treated with reduced stimulation and medication with phenothiazine. She was relatively comfortable with this regimen, but became agitated when she went home on a pass, and when plans for discharge were discussed. It was felt that treatment had reached an impasse and she could not be discharged home. She was transferred to a nearby state hospital with the prediction that she would improve if left alone there. This seems to be occurring at present.

DISCUSSION

There is a good deal of non-psychiatric literature concerning one's need for privacy and solitude, ranging from the legal (Ernst & Schwartz, 1962) to the literary (Fromm-Reichmann, 1959). The history of psychiatric treatment is the history of intrusion (Scher, 1957) and can be followed from Homer to Hippocrates to Benjamin Rush to a present-day author (DesLaurier, 1962) who states: 'The therapist must establish himself as the most important intruding factor...a forceful, insistent, intruding presence.' Since almost everything conceivable has been done to patients at one time or another (Bellak, 1958; Lovett Doust & Schneider, 1954) no history exists of the phenomenon of doing nothing. We have chosen to concentrate on reviewing this phenomenon in the treatment of psychosis, and have used working concepts of stimulation, distance and the psychological meaning of being alone.

(1) Overstimulation

The role of overstimulation in psychopathology is usually considered in the traumatic neuroses, but is pertinent to a study of the psychoses. All individuals need to develop a protective shield against external stimuli which can overwhelm the infantile ego (Freud, 1915, 1920). Failure of the protective barrier can lead to premature ego formation and subsequent psychotic manifestations (Bergman & Escalona, 1949). This barrier can be theoretically thin or imperfect from lack of early maternal protection, or from early hyperstimulation. The organism always seeks out stimuli in its search for satisfaction and constancy (Fenichel, 1945). The schizophrenic apparatus is considered to have an insufficient barrier to stimulation (Eissler, 1947) and can be easily overwhelmed by all sorts of perceptual cues (Eissler, 1954). An excellent review of most of the literature on schizophrenia and stimulation by McReynolds (1960) reaches the conclusion that schizophrenia is caused by an excessively high level of unassimilated percepts. He feels that certain characteristics of schizophrenics are attempts to prevent unassimilated material from becoming greater or to assimilate these percepts. It is felt that therapy should provide novel and varied experiences at a kind and rate that the patient can assimilate. However, he ignores the possibility of ordering the environment so as to reduce the percepts. The stimuli problem also involves studies in sensory deprivation and schizophrenia (Azima & Cramer, 1956; Harris, 1959; Smith et al. 1961). There is abundant literature on sensory deprivation being similar in symptomotology to that of schizophrenia. Yet some schizophrenics tolerate deprivation better than normals. The evidence from this research is still contradictory, with some authors indicating sensory deprivation as the paradigm of schizophrenia and others the contrary (Rosenzweig, 1959). In general, it is felt that the schizophrenic problem is unique. There is evidence that schizophrenics are involved with avoidance of stimuli (Arieti, 1955; Lang, 1959; Postman, 1953; Rodnick & Garmezy, 1957; Venables & Tizard, 1958; Webb, 1955), and many authors discuss the schizophrenic's need for isolation (Jaco, 1954), insulation (Spotnitz, 1962), a breathing spell (Bellak, 1958) and a splinting.

In summary, we can state that there is a definite connexion between quantity of external stimuli (Chapman & McGhie, 1962;

Donahoe *et al.* 1961) (and therefore of internal stimuli) and the ability of the person to handle these stimuli. The economics of the mind indicate that a period of being in a state of diminished external stimuli serves as therapeutic for many individuals (Walters *et al.* 1963).

(2) *Distance*

The interpersonal viewpoint allows the problem of the therapeutic effectiveness of being alone or separate to be considered as the concept of distance. Mahler & Furer (1963) state that the separation process of the child from the mother is the prerequisite for normal individuation. She distinguishes the child's passive experience of being separated from the mother from the child's experience of separate functioning in the presence of the mother. Problems of closeness have been dealt with by many authors in the therapy of psychosis. Stierlin (1961) discusses the therapist's and the patient's tendency to re-enact the deep entanglements characteristic of the schizophrenic's early relationships, and urges growth-permitting relationships with 'structured distance'. This is somewhat echoed by Wexler (1953), who says the psychiatrist's own anxiety is often the motivation to get close to the patient. Bouvet (1958) states that the initial treatment of schizophrenics helps to establish distance, though his definition of this concept seems highly personal. The double-bind hypothesis (Haley, 1959) states that contradictory explicit and implicit messages lead to confusion and anxiety and are often the main communication in schizophrenic families. In a discussion of this hypothesis, Weakland (1960) stresses a point which we feel is often overlooked, i.e. 'leaving the field or escaping, followed by establishment of more satisfactory communication elsewhere, would be one potential avenue of natural or adequate response. Its unavailability usually is an outcome of dependence in the person(s) giving the contradictory messages.' Will (1959) feels that the schizophrenic patient needs aloneness and isolation for later mutuality

to occur. Other authors (Kohn & Clausen, 1955; Scott 1958; Thomas & Wilson, 1949) speak of the seclusiveness and isolation of the schizophrenic as both pathology and defence. An interesting example of the use of distance in the treatment of schizophrenics is developed by Sivadon *et al.* (1962), using some of Piaget's and Wallon's concepts. He feels that patients must first distinguish themselves from the environment and then must re-order percepts from the simple to the more complex (Singer, 1960). He therefore arranges the environment first to isolate and then involve the patient in a gradient manner.

(3) *Psychological factors*

Aside from the economic and interpersonal considerations, therapeutic neglect can be studied in a more dynamic sense. The literature and illustrated cases suggest some of the dynamics of aloneness.

Schwartz (1962) discussed the issue of paradoxical remission of psychosis in terms of hopelessness, but omits the genetic and historical pertinence in his patients. Boverman (1955) introduces a concept repeated by Biddle (1949) that patients can re-integrate around the figure of a person who has a friendly interest with no therapeutic intent (Schauer, 1945). This may highlight the issue of the therapists' need to cure and a resultant negative therapeutic reaction. Other suggested and somewhat similar ideas deal with the patient's being in a hospital with substandard conditions and getting better in order to get out. General discussions of the integrative factors of isolation are given by Alexander & French (1946) who advocate periods of separation in the treatment of neurotics, Fromm-Reichmann (1959) who feels that self-induced solitude can be constructive and that such states of constructive aloneness are essential to all creative originality, and Winnicott (1958) who discusses the developmental level necessary for being able to be alone.

Although all of the patients described above had psychotherapy, it might be argued that

the treatment was not what it might have been. However, the therapists were well-trained and yet peculiarly stymied in their treatment at various phases. Case no. 1 was that of an overstimulated boy who evoked intrusiveness in others. He experienced separation at an early age when sent to visit his aunt, and re-experienced it when sent to the state hospital. It was felt that this allowed him to establish meaningful distance between himself and others so as better to tolerate his hostile and destructive impulses. Case no. 2 seems to illustrate a basically neglected boy who experienced erratic overstimulation with resultant failure to develop an adequate stimulus barrier. He needed a prolonged period of withdrawal. Case no. 3 is of a person who seemed deeply disappointed in mothering and had to do everything for herself. She only admitted to not needing anyone; everyone was an intrusion. Case no. 4 illustrates how intrusion, when invited, can precipitate psychotic behaviour. Here again the concept of distance seems pertinent. Case no. 5 is probably unique in illustrating recovery through satisfaction of a need for punishment, i.e. identification with a neglected person. Case no. 6 illustrates the problem of intrusiveness and overstimulation with the patient deciding what she could tolerate in a relationship. It was accurately predicted that this patient would recover when sent to a state hospital.

Essentially the above cases illustrate the described working concepts of overstimulation and distance with the added factor of the individual meaning of aloneness. There are indications in each case of the reparative aspects of this state, especially in the schizophrenic. Although in sociologic studies isolation is often described as part of the schizophrenic pathology, (Jaco, 1954; Kohn & Clausen, 1955) there is an intrapsychic aspect which can be reparative at certain times.

Conclusion

There seems to exist a valid place in the therapy of some psychiatric patients for the idea of their experiencing separation and distance. These patients are often those who have a history of overstimulation and/or whose acute upset is related to a period of overstimulation. Theoretically, such patients have problems in controlling external and internal stimuli and treatment should be considered as helping the patient in ordering and regulating such stimuli (Brown, 1962; Feldstein, 1962; Gottschalk et al. 1961). The integrative factor of isolation allows one to make external stimuli meaningful (Kantor & Winder, 1959) by allowing the level of internal excitation to decrease. These patients are usually those who have problems with establishing and controlling the distance (closeness) (Harris & Metcalfe, 1959; Johannsen, 1961) between themselves and others, wherein intrusion is historically significant and of a frightening intensity. Intrusive persons are seen as overstimulating, disrupting, and not allowing separation and autonomy (Rashkis & Singer, 1959). Therapeutic intrusiveness, therefore, may repeat the intolerable ambivalent ties to the original objects. The patients' history will usually uncover a more dynamic meaning and often will indicate positive aspects of their supposed neglect. These probably relate to early experiences of mothering and are positive in the sense of a reparative attempt dealing with unhealthy mothering. This may be re-experienced with the use of non-intrusive persons (Weinshel 1952) or entirely alone. The patient may then be ready to enter into closer relationships with better regulation of stimuli, structured distance and varied objects.

Summary

The paper is an investigation of the phenomena of psychiatric patients recovering during periods of supposed neglect. Some cases are cited as examples and considered from the points of view of overstimulation, distance, and the various psychological meanings of aloneness. The appropriate literature is reviewed and an attempt is made to delineate the kinds of patients benefiting from being left alone.

REFERENCES

ALEXANDER, F. & FRENCH, T. M. (1946). *Psychoanalytic Therapy*. New York: The Ronald Press Co.

ARIETI, S. (1955). *Interpretation of Schizophrenia*, New York: Robert Brunner.

AZIMA, H. & CRAMER, F. (1956). Effects of partial perceptual isolation in mental disturbed individuals. *Dis. Nerv. System*, **17**, 117–22.

BELLAK, L. (1958). *Schizophrenia: a Review of the Syndrome*. New York: Logos Press, Inc.

BORGMAN, P. & ESCALONA, S. (1949). Unusual sensitivities in very young children. *Psychoanalytic Study of the Child*, **3–4**, 333–52. New York: International Universities Press, Inc.

BIDDLE, W. (1949). The nurse and 'spontaneous' recovery in schizophrenia. *Amer. J. Nursing*, **49**, 371–2.

BOUVET, M. (1958). Technical variation and the concept of distance. *Int. J. Psycho-Anal.* **39**, 211–21.

BOVERMAN, M. A. (1955). A factor in 'spontaneous' recovery. *Bull. Menninger Cl.* **19**, 129–34.

BROWN, G. W. *et al.* (1962). Influence of family life on the course of schizophrenic illness. *Brit. J. Prev. Soc. Med.* **16**, 55–68.

CHAPMAN, J. & McGHIE, A. (1962). A comparative study of disordered attention in schizophrenia. *J. Ment. Sci.* **108**, 487–500.

DESLAURIER, A. M. (1962). *The Experience of Reality in Childhood Schizophrenia*. International Universities Press, Inc.

DONAHOE, J. W. *et al.* (1961). Interference effect with schizophrenic subjects in the acquisition and retention of verbal material. *J. Abnorm. Soc. Psychol.* **62**, 553–8.

EISSLER, K. R. (1947). Psychiatric ward management of the acute schizophrenic patient. *J. Nerv. Ment. Dis.* **105**, 397–402.

EISSLER, K. R. (1954). Notes upon defects of ego structure in schizophrenia. *Int. J. Psycho-Anal.* **35**, 141–6.

ERNST, M. L. & SCHWARTZ, A. U. (1962). *Privacy: The Right to be Let Alone*. New York: The MacMillan Co.

EYSENCK, H. J. (1963). Behaviour therapy, spontaneous remission and transference in neurotics. *Amer. J. Psychiat.* **119**, 867–71.

FELDSTEIN, S. (1962). The relationship of interpersonal involvement and affectiveness of content to the verbal communications of schizophrenic patients. *J. Abnorm. Soc. Psychol.* **64**, 39–45.

FENICHEL, O. (1945). *The Psychoanalytic Theory of Neurosis*. New York: W. W. Norton and Co., Inc.

FREUD, S. (1915). *Instincts and their Vicissitudes*. Standard edition, vol XIV. London: The Hogarth Press.

FREUD, S. (1920). *Beyond the Pleasure Principle*. Standard edition, vol. XVIII. London: The Hogarth Press.

FROMM-REICHMANN, F. (1959). On loneliness. *Psychiatry*, **22**, 1–15.

GOTTSCHALK, L. A. *et al.* (1961). Further studies on the speech patterns of schizophrenic patients. *J. Nerv. Ment. Dis.* **132**, 101–13.

HALEY, J. (1959). An interactional description of schizophrenia. *Psychiatry*, **22**, 321–32.

HARRIS, A. (1959). Sensory deprivation and schizophrenia. *J. Ment. Sci.* **105**, 235–37.

HARRIS, A. & METCALFE, M. (1959). Slowness in schizophrenia. *J. Neurol. Neurosurg. Psychiat.* **22**, 239–42.

JOHANNSEN, W. J. (1961). Responsiveness of chronic schizophrenics and normals to social and non-social feedback. *J. Abnorm. Soc. Psychol.* **62**, 106–13.

JACO, E. G. (1954). The social isolation hypothesis and schizophrenia. *Amer. Sociol. Rev.* **19**, 567–77.

KANTOR, R. E. & WINDER, C. L. (1959). The process-reaction continuum: a theoretical proposal. *J. Nerv. Ment. Dis.* **129**, 429–34.

KOHN, M. L. & CLAUSEN, J. A. (1955). Social isolation and schizophrenia. *Amer. Sociol. Rev.* **20**, 265–73.

LANG, P. J. (1959). The effect of aversive stimuli on reaction time in schizophrenia. *J. Abnorm. Soc. Psychol.* **59**, 263–8.

LOVETT DOUST, J. W. & SCHNEIDER, R. A. (1954). Rhythmic sensory bombardment therapy (R.S.B.T.): a new treatment for patients with psychiatric disorders. *Amer. J. Psychiat.* **110**, 854–5.

MAHLER, M. S. & FURER, M. (1963). Certain aspects of the separation-individuation phase. *Psychoanalytic Quart.* **32**, 1–14.

McReynolds, P. (1960). Anxiety perception and schizophrenia. In *The Etiology of Schizophrenia*, ed. D. D. Jackson, pp. 248–92. New York: Basic Books, Inc.

Postman, L. (1953). On the problem of perceptual defense. *Psychol. Rev.* **60**, 298–306.

Rashkis, M. A. & Singer, R. D. (1959). The psychology of schizophrenia. *A.M.A. Arch. Gen. Psychiat.* **1**, 406–16.

Rodnick, E. H. & Garmezy, N. (1957). An experimental approach to the study of motivation in schizophrenia. In *Nebraska Symposium on Motivation*, pp. 109–84. Lincoln: University of Nebraska Press.

Rosenzweig, N. (1959). Sensory deprivation and schizophrenia: some clinical and theoretical similarities. *Amer. J. Psychiat.* **116**, 326–9.

Schauer, G. (1945). Patients as therapeutic agents in a mental hospital. *Sociometry*, **8**, 394–5.

Scher, J. M. (1957). Perception: equivalence, avoidance and intrusion in schizophrenia. *A.M.A. Arch. Neurol. Psychiat.* **77**, 210–17.

Schwartz, D. A. (1962). Paradoxical remission of psychosis. *A.M.A. Arch. Gen. Psychiat.* **6**, 315–19.

Scott, W. A. (1958). Social psychological correlates of mental illness and mental health. *Psychol. Bull.* **55**, 65–85.

Singer, R. O. (1960). Organization as a unifying concept in schizophrenia. *A.M.A. Arch. Gen. Psychiat.* **2**, 61–74.

Sivadon, P. *et al.* (1962). Contribution à la Readaptation Sociale des Malades Mentaux par les Activites Physiques and Sportives. In *Seminarie du Comite de Recherches du Conseil International de l'Education Physique et des Sports*. Paris.

Smith, S. *et al.* (1961). Perceptual isolation and schizophrenia. *J. Ment. Sci.* **107**, 838–44.

Spotnitz, H. (1962). The need for insulation in the schizophrenic personality. *Psychoanalysis*, **49** (no. 3), 3–25.

Stierlin, H. (1961). Individual therapy of schizophrenic patients and hospital structure. In *Psychotherapy of the Psychoses* (ed. A. Burton), pp. 329–48. New York: Basic Books, Inc.

Thomas, G. C. G. & Wilson, D. C. (1949). Recognition of pre-schizophrenic states. *Virginia Med. Mon.* **76**, 405–9.

Venables, P. H. & Tizard, J. (1958). The effects of auditory stimulus intensity on the reaction time of schizophrenia. *J. Ment. Sci.* **104**, 1160–4.

Walters, R. *et al.* (1963). Effect of solitary confinement on prisoners. *Amer. J. Psychiat.* **119**, 771–3.

Weakland, J. W. (1960). The 'double-bind' hypothesis of schizophrenia and three-party interaction. In *The Etiology of Schizophrenia* (ed. D. D. Jackson), pp. 373–88. New York: Basic Books, Inc.

Webb, W. W. (1955). Conceptual ability of schizophrenics as a function of threat of failure. *J. Abnorm. Soc. Psychol.* **50**, 221–4.

Weinshel, E. M. (1952). The psychotherapeutic aspects of schizophrenia. *J. Nerv. Ment. Dis.* **115**, 471–88.

Wexler, M. (1953). Psychological distance in the treatment of a schizophrenia patient. In *Exploration in Psychoanalysis* (ed. R. Lindner), pp. 163–72. New York: Julian.

Will, O. A., Jr. (1959). Human relatedness and the schizophrenic reaction. *Psychiatry*, **22**, 205–23.

Winnicott, D. W. (1958). The capacity to be alone. *Int. J. Psychoanal.* **30**, 416–20.

Reviews

Psychiatry for Students. By DAVID STAFFORD-CLARK, with a chapter on 'Child Psychiatry' by Gerard Vaughan and an appendix on 'Clinical Psychology' by Jessie Williams. (Pp. 277. 35s.) London: George Allen and Unwin Ltd.

The need for the teaching of psychiatry has at long last been recognized in the British medical schools after centuries of neglect. There is a growing demand for text-books which are lucid and concise and also take into consideration the very limited amount of time allowed for psychiatry in the curriculum. This book is a welcome addition to the student's library. Its chief author is a born communicator who has contributed a great deal towards the understanding of psychological illness among the lay public. He is also an experienced and stimulating clinical teacher. His text-book reflects these qualities as well as a genuine compassion for the mentally ill. It conveys the excitement of psychiatric clinical work and tries to give the student an idea of how it feels to be a patient. The approach is that of psychodynamics married to clinical medicine. The presentation is practical and imbued with reasonable therapeutic optimism. Some of the clinical definitions, such as that of dementia, are more individualistic than behoves a text-book which is likely to be read all over the Commonwealth and one could argue about the balance of the material presented. However, these are minor criticisms. The book has many admirable features and will no doubt be popular with students and teachers alike. E. STENGEL

Handbook of Community Psychiatry. Edited by LEOPOLD BELLAK, M.D. (Pp. 454. $ 14.50.) New York and London: Grune and Stratton.

This book is of considerable interest. It brings together contributions from many of the leaders in the field of social and community psychiatry in the United States. It is not an enjoyable book to read because it is patchy and at times rather disjointed. Inevitably, as the concept of community psychiatry is so new, the articles are largely theoretical and lack validation. To the reviewer it

tends to highlight many of the differences between the British and the American scene. Many of the papers seem to be unnecessarily long and are badly written. There is a striking overemphasis on the academic with the utilization of social science concepts and language. One has a feeling that many of the contributors are talking from a theoretical rather than a practical standpoint and that Britain has had a much longer first-hand experience of community psychiatry. Nevertheless, the Americans with their usual thoroughness are trying to formulate the basic concepts in the field of community psychiatry and apply to these future training needs in this field. The community mental health centre has come to play an increasingly important part in the American scene but how far these centres will provide adequate psychiatric care for the lower social economic groups is an open question. The role of the community psychiatrist is extended considerably to include the mental health consultant. Thus, in centres in the States of Massachusetts, New York and California and others, the mental health consultant has been added to the familiar clinical triad of psychiatrist, psychologist and psychiatric social worker. Clarence Haylett and Lydia Rapoport contribute a very thought-provoking chapter on the role of the mental health consultant in the prevention and treatment of psychiatric disorders in the community. The basic training of these consultants has been in psychiatric social work, clinical psychology and dynamic psychiatry. They go far beyond the familiar role of the psychiatrist in this country and concern themselves with the improvement of existing professional personnel, various forms of mental health and educational activities. They describe mental health consultation as a process of interaction between a mental health professional and one or more 'consultees' for the purpose of increasing the consultee's awareness of, and ability to manage, the mental health components of his work. The consultant has no administrative control over the consultee and each has his own area of competence. This type of training, which is now developing in a few of the American universities, would seem to be immensely important to the development of an

adequate liaison between the National Health Service and the Local Authority in this country. Many psychiatrists and social workers are, of course, playing this role but the Americans clearly think that an extended training in the social sciences in particular is necessary. The Leightons and Roderick Armstrong contribute a chapter on community psychiatry in a rural area. This is a valuable condensation of the findings of the well-known Stirling County project. In their analysis of a community in Nova Scotia they found that twenty per cent of the population seemed to require psychiatric help. They found that individuals from a disintegrated community showed the impact of this on the mental health of the community. More individuals were rated as cases, individuals had a greater number of different kinds of symptoms etc. compared with those from more integrated communities. Gerald Caplan has an important chapter on the role of paediatricians in community mental health. He has some interesting things to say on prevention. At times when individuals find themselves inadequate to cope with a situation, the situation should, if possible, be used for the furtherance of emotional development. The successful coping with such situations leads to the maintenance of mental health. In America a great deal of attention is being paid to crisis situations and their solution and Caplan talks of capitalizing on current experience in order to help the individual to prepare for future crises in a group situation. This technique was used in preparing Peace Corps volunteers to deal with the loneliness and isolation which they will almost inevitably encounter when they go overseas. To the British reviewer it seems that very little is made of the role of the mental hospital in the developments of community psychiatry. The publication *Action for Mental Health* implied that the Americans have largely decided to bypass their unwieldy and poorly staffed state hospitals and concentrate on the newer concept of community mental health centres. The relative disorganization which, as yet, represents this endeavour is brought out in this book. It contains an immense amount of valuable information and it would be a grave mistake to underestimate the vast reorganization that is at present occurring in the United States. How far these efforts will be able to overcome the handicap of large vested interests, particularly in the private practice of psychiatry, and how far Federal and State funds

will become available remains to be seen. The prejudice against socialized medicine which is so common in the U.S. may well slow up developments. Community psychiatry developed largely from the mental hospitals in Britain but in America every attempt is under way to develop better services through the mental health centres and with the backing of the medical schools. The relative absence of the family doctor in the American scene is only one of the numerous factors which make a comparison between the two countries both difficult and often misleading. For any Britisher interested to learn from his American colleagues in the field of community psychiatry this book is an invaluable reference.

MAXWELL JONES

Clinical Correlations of Experimental Hypnosis. Compiled and edited by MILTON V. KLINE. (Pp. 512. $15.75.) Springfield: C. C. Thomas. 1963.

This volume is essentially a selected collection of papers previously published in several journals, mostly in the U.S. At first sight it may appear to be an undisciplined collection. It includes papers on transference in hypnotic trance, aspects of dreams in hypnosis, the influence of hypnosis on the learning process, the influence on gastric processes of hypnotically induced emotional states, experiments on substitution of psychodynamically equivalent symptoms by hypnosis, removal of warts by hypnotic suggestion, abolition of skin responses in allergy by hypnotic suggestion, as well as other topics of varied interest. The unifying theme of this collection is the integration of good experimental studies using hypnosis with practical clinical concepts, with a view to stimulating interest and further research on the uses of hypnosis. The first part of the book contains a number of general papers presenting constructs based on theory, experimental research and clinical practice. These perhaps suffer somewhat from too much theorizing.

This is not a text-book of hypnosis. Nor is it a book for beginners. It is easier to absorb by intermittent rather than by continuous reading. It should be of value to clinicians whether or not they are interested in research techniques. Some may find difficulty in accepting many of the therapeutic implications. However, one cannot

fail to be stimulated by the potential use of hypnosis as a research tool and as an aid to therapy.   DAVID M. KISSEN

Psychiatry and Psychology. By H. L. SILVER-MAN. Illinois, U.S.A.: Charles C. Thomas. 1963.

The subtitle of this essay (the main text occupies only 60 pages) is 'Relationships, Intra-Relationships and Inter-Relationships', and after reading this, one is prepared for the worst. In the subsequent pages the author attempts to evaluate the two disciplines of psychiatry and psychology and to examine some of the problems which at present prevent members of the two professions achieving a harmonious working relationship. Dr Silverman appears to see the clinical psychologist as a psychotherapist who has the additional qualification of being trained in such 'sharp diagnostic tools' as the Rorschach Test, which we are told 'the psychiatrist has come to depend on evaluatively'. There is little here that is in any way relevant to the practice of these two professional disciplines in this country, and the reader might doubt if the author gives a fair picture of the current state of affairs in his own country. There is little or no reference to the psychologist's training in experimental methodology or to his contribution to psychiatric research, the author's main preoccupation being with the psychotherapeutic functions of psychiatrists and psychologists. The book ends with a plea for 'a team approach that offers the patient a type of service that will be contiguous, collateral, ancillary, articulative and integrative'. This type of statement appears to present a sound case for more research on communication theory.   ANDREW MCGHIE

Introduction to the Work of Melanie Klein. By HANNA SEGAL. (16s.). William Heinemann, Medical Books Ltd.

This book is based on a series of lectures given by the author over a number of years at the Institute of Psychoanalysis in London. It contains a simplified and schematic description of the late Mrs Melanie Klein's contributions to psychoanalytical theory and practice. It is not meant to be a substitute for the study of the relevant liter-ature, and a bibliography at the end of every chapter is a helpful guide to further reading. It is a stimulating and up-to-date account, including hints of the directions in which this important aspect of psychoanalytical knowledge is likely to follow in future.

The chapter on Phantasy shows the ways in which Freud's concept of unconscious phantasy has been extended and given more weight by Klein's work. Accounts of the beginning of the 'paranoid-schizoid position' and the 'depressive position' in early infancy, manic defences, reparation, and the early stages of the oedipus complex are beautifully presented in subsequent chapters, in a literary style which is a gift already familiar to those who have read Dr Segal's other work. Doubts may arise in some readers' minds and a need for further study of controversial issues. Adherents to other schools of psychology will easily question the validity of concepts or suggest different ones. But one issue should convince most readers, namely the necessity for the infant's safe transition, through painful effort, from the early use of paranoid and schizoid mechanisms of defence to a capacity for tolerating depressing reality, guilt and an urge to make reparation, with a surer hope of future stability.

Separate reference must be made to the chapter on Envy. It is now well known that Melanie Klein made important additions to the concept of envy postulated by Freud. In addition to penis-envy in women, the spoiling effects of unconscious envy on the vital relationship to the mother's breast, occurring in male and female alike, are explained. Dr Segal's belief that powerful unconscious envy often lies at the root of negative therapeutic reactions and interminable treatments is well worthy of note.

Theoretical statements are illustrated by clinical material in all chapters, and while, inevitably, even sophisticated readers may sometimes query details of interpretation and think of alternative meanings, they will feel the dynamic progress of development in the patients described. And in places, immediate responses to interpretations may well convince more sceptical readers that a true insight is being achieved. This is not to idealize, for years of study in the author's postgraduate seminars lessen such a tendency, and give place to a genuine appreciation of keen analytic perception in a person who has achieved mastery of her speciality.

This excellent short book does honour to the memory of a great pioneer in the field of medical psychology. Psychologists and psychiatrists who try to understand the part played by unconscious phantasy in the development of neuroses and psychoses will find it helpful, as will also anyone engaged in the psychotherapy of adults or children. It is in a sense more than an Introduction and will bring extra illumination to those already versed in Melanie Klein's work.

SIMON LINDSAY

Emotions and Emotional Disorders. By ERNST GELLHORN and G. N. LOOFBOUROW. (Pp. xii+496. Price £2.) London: Hoeber Medical Division. 1963.

This is an important book for psychiatrists, psychoanalysts and psychologists who are interested in keeping abreast of recent developments in neurophysiology as they relate to normal and abnormal psychological phenomena. This book covers a wide range of topics, each one being discussed from the point of view of the activity of the autonomic nervous system. The subjects covered range from an account of the physiological bases of emotion to a discussion of autonomic nervous system functioning in mental disorders. Of particular interest is the detailed account of the means whereby sympathetic and pathetic reactivity can be gauged and used as an index of hypothalamic function.

It is unfortunate that this book will be read more often by those whose interest lies in the somatic aspects of psychiatry. For them it will serve as a useful guide to current neurophysiological knowledge, theory and techniques of investigation. At first sight this work may appear to have little to offer to the psychotherapeutically oriented psychiatrist. The contrary is in fact true. Apart from reminding him of the physical basis of mind it will also make him think about the contributions which psychodynamic principles can make to psychophysiological research. The authors take full cognisance of the complexity and variability of psychological phenomena and there is no attempt to oversimplify or gloss over difficulties which are inherent in research conducted with human subjects. Work of this kind may help to lessen the distance which still exists between somatically and psychologically minded psychiatrists.

THOMAS FREEMAN

Developmental Dyslexia. By MACDONALD CRITCHLEY. (Pp. 104. 25s.) London: William Heinemann Medical Books Ltd. 1964.

In this book the author traces the growth of our knowledge of what is now called 'specific developmental dyslexia' from its first detection by Hinshelwood, the Glasgow ophthalmologist, in 1895, through its investigation by later workers from Samuel T. Orton onwards. He extracts what is of value from the very influential work of the educational psychologists who reacted against the earlier and perhaps excessively aphasiological approaches to the subject. On p. 10, the author lumps together and expounds, rather imprecisely, the separate and distinct arguments of Hermann and Larsen. Hermann's argument was that the allegedly smooth distribution curve of reading ability constructed by Tordrup was, in fact, humped, and did not support Tordrup's own conclusion (widely accepted by educational psychologists) that dyslexics comprise nothing more than the lower end of a normal distribution curve. It supported, rather, the view that one or more specific defects were to be taken into account.

The author, unlike Vernon, is impressed by the genetic findings of Hallgren that the condition has a monohybrid autosomal dominant mode of inheritance and an incidence, at least in Sweden, as high as 10%. He points out how little we know of the eventual outcome in these cases and advocates post-mortem studies—although these would probably be of little value unless the neuropathologist was thoroughly conversant with the statistically based studies of the normal cyto-architectonic maturation of the brain as investigated minutely by Conel in recent years. He emphasizes that emotional disturbance is secondary and not, as many educational psychologists, and not a few child psychiatrists (including Mildred Creak), would have us believe, causal, supporting his argument effectively with the findings of Lynn, the educational psychologist, that anxious children tend, rather, to be precocious readers and the conviction of Schilder, the psychoanalyst, that it is from the neurological point of view that the condition is to be interpreted.

Dr Critchley attributes to Sir Cyril Burt the fallacy that dyslexics are totally incapable of learning to read and points out that if the condi-

tion is due to a variable immaturity of cerebral (?parieto-occipital) development a potential for improvement would be expected. This suggestion is, in fact, borne out by P. D. Scott's impression that many delinquent non-readers succeed in teaching themselves to read, in later adolescence, after leaving school. The author, in contra-distinction to the advice given by the English Ministry of Education in its booklet on backward readers, emphasizes the special value of the old-fashioned analytic-synthetic, as opposed to the global, look-and-say, method of teaching dyslexics. But he insists that this remains a technical problem in the field of educational psychology. He discusses the relative desirability of the provision of special establishments or a corps of special teachers and emphasizes that a systematic diagnostic service would also be required.

In the text the names of at least twenty authors, with dates, appear, who have no corresponding entry in the bibliography. Also, as a result of an ironically 'strephosymbolic' mistake on p. 8, Orton is said to have come on the scene in 1952 when, of course, it was 1925. There is an unnecessary typographical inset of a paragraph at the bottom of p. 10. Despite these, and a number of other minor misprints and puzzles, this is a book in which it is a relief to have, at last, our present knowledge of this important disability put into its proper perspective by such an eloquent and acknowledged expert on the functions of the brain.

JAMES F. MCHARG

Gestalten und Gedanken. By ERNST KRETSCHMER. (DM. 28). Stuttgart: Thieme. 1963.

This is a charming autobiography written by one of the greatest living European psychiatrists, who has made outstanding contributions to many different fields. Prof. Kretschmer is one of the few German psychiatrists of his generation who devoted much time to the problems of psychotherapy. The reason for this quickly becomes obvious to the reader of this book.

One cannot help being impressed by the author's sincere humanity and deep feeling for others. Kretschmer's humanity is not something purely for outward show. Unfortunately, during the domination of the Nazis some German psychiatrists forgot they were doctors, and co-operated in the extermination of the mentally ill. However, there were many like Kretschmer who opposed such barbaric ideas at the risk of their lives and careers.

Perhaps the greatest contribution of Kretschmer to psychiatry is his general approach which takes into account both psychological and constitutional factors. His ideas on these subjects are clearly put forward in this book, which should be read by everyone interested in the recent history and general problems of clinical psychiatry.

FRANK FISH

Psychiatry on the College Campus. By Dr H. G. WHITTINGTON. (Pp. 319. $ 7.50.) New York: International Universities Press Ltd.

This is a comprehensive account of the setting and work of the Mental Health Service of the University of Kansas. Despite the limited number of similar workers in this country for whom the book will be of direct relevance, there will be a wider appeal to readers engaged in work with young people, or concerned with the problems of short-term psychotherapy and its evaluation.

After describing the conflicting pressures to which the college student is subjected—from administration, faculty and parents—he considers in what way the Mental Health Service can hope to prevent mental illness. Early recognition of emotional difficulty may be achieved by various screening devices, but such case-finding in adolescents may be harmful by producing dependency and interfering with their own problem-solving capacities.

The patients seen in the clinic cover a wide variety of diagnostic categories, but because of the university setting the length of treatment is limited. He deals at length with the techniques of individual and group psychotherapy that are used, including a follow-up on cases seen during one year. The book closes with appendices of general interest; an outline of a systematic recording of relevant clinical data and data collection guides for follow-up studies.

ENID CALDWELL

A Study of Brief Psychotherapy. By D. H. MALAN. Mind and Medicine Monographs. (Pp. 312. 35s. net.) Tavistock Publications.

In this study of brief psychotherapy, as carried out by a group of psychoanalysts, Dr Malan gives an account which is of interest to both

therapists interested in the techniques involved and workers concerned with assessment of results of various forms of treatment. He opens with a historical and theoretical survey which illustrates how each new treatment inevitably becomes more lengthy and his review of previously published results of brief psychotherapy reveals how poorly documented are the results of treatment and how inadequate are the follow-ups.

The present work in contrast is strictly limited to short-term psychotherapy with a thorough documentation of the treatment and follow-up of twenty-one cases. The conclusion which he draws from this study is in opposition to the conservative school of thought which feels that 'mild' illnesses of recent onset have the best prognosis and that transference interpretations should be avoided. His findings are that lasting improvement in neurotic behaviour patterns can be obtained in patients with moderately severe and long-standing illnesses, that thorough interpretation of the transference plays an important part and that cases can be usefully selected on the basis of motivation, capacity for insight and ability to respond to interpretations.

ENID CALDWELL.

Publications of the British Psychological Society

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The British Journal of Medical Psychology

The British Journal of Psychology
(Monograph Supplements)

The British Journal of Educational Psychology
(Jointly with The Association of Teachers in Colleges and Departments of Education)

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The significance of the actual historical event in psychiatry and psychoanalysis*

By SAMUEL NOVEY

In the search for anamnestic data in any sphere of medicine, including the psychological one, the tacit assumption is made that a historical or developmental approach will reveal factors of importance. In physiological disordered states, in addition to obtaining a history, attempts are made to supplement and validate the historical information by means of various laboratory tests and by the physical examination of the patient. The essential emphasis is placed upon the validatable historical event. As opposed to this, in psychological medicine the *reported* historical event is of central importance whether or not it can be validated since it constitutes a reported event of psychological significance to the patient. There are occasions even in the latter, however, where the need to validate reported historical events becomes a matter of primary importance both as a research endeavour and as a necessary condition for the conduct of therapy.

In a previous paper (Novey, 1962), a relativistic view of history was taken. Emphasis was placed upon the importance of the interpretation placed on historical events in the patient's life. This is especially true in so far as memories elicited from the patient are employed during the therapeutic process. Only secondarily does the question of precise coincidence with the actual course of events become a matter of such importance as to warrant a search for supporting data in the form of documents or the evidence of other persons in the form of their substantiating memories. This in no sense belittles the importance of the remembered event as a critical aspect of the therapeutic process but

it stresses the particular use that is made of such memories as part of the re-organization of experiences intrinsic to therapy. While there is no question but that past experiences are imprinted in some fashion and thus influence thinking, feeling, and behaviour it is quite another matter to validate the occurrence of any specific historical event and to appraise its specific impact on personality organization. Events have a sense of reality for the patient whether they coincide with actual external events or not. This is not to say that such coincidence is a matter of no moment. In the study of history itself the distinction is made between propaganda and history. In the former, events are distorted for particular ends while in the latter great care is used, in so far as it is possible, to verify and reproduce as close an image as documents and the intuition of the historian will permit.

The memory of past events both as idea and feeling should ideally constitute a means of avoiding the repetition of past errors and also of perseverating successful patterns of performance. Or, more informally, we say 'we learn from experience'. In the emotional disorders, a critical role is played by the dysfunction of the memory process, limiting learning and making for the repetition of maladaptive behaviour. Also, in the instance of young children, the limitations of this adaptive process is conspicuously visible. They live only in the present since they have no historically organic ideas in mind. Thus, historical reconstruction is an intrinsic part of the process of therapy. An attempt is made to see the patient and have him see himself in some continuing context in which his present modes of experiencing and of dealing with himself and others are a logical outgrowth.

* Read before the Western New England Psychoanalytic Society, 11 January 1964.

This historical reconstruction asks us to meet what, on the face of it, would appear to be the simplest of conditions. It requires a verbal statement of why a total mass of evidence draws us to a given conclusion and no other one and why and how this conclusion would be different if significant elements of the evidence had been different. Unfortunately, to meet these conditions in any absolute sense is impossible and we can do no more than strive towards this goal.

What we commonly describe as an historical event is composed of the actual happening and our assumptions about the meaning of the happening. These are usually so fused together that we tend not to realize that we are doing other than reporting an actual happening. If we are told by the patient that he had thus and such an experience with his father at age 5 this is not simply reported or presently experienced as cold fact devoid of meaning. By implication or direct statement it is an interpretative communication with which the therapist may or may not concur, and if he does not, he must eventually be prepared to offer alternate interpretations. Perhaps a sample of a physical phenomenon will emphasize the degree to which we are dependent upon assumptions about events. We say the electricity is 'on' hence the room is illuminated. There is the assumption that some kind of force, not to be seen, is being communicated through the wire to a tungsten filament and is illuminating the room. Just so, we engage in similar propositions about human behaviour be it our own or others. In the above instance, it is implied that the son's version of the happening with his father derived in anger or love or jealousy, etc.

As further background to the question of what attitude should be taken towards the reported history, it is useful to trace the ways that others have struggled with this problem, with more or less success, in the past. An old and tantalizing problem with which Freud (1898) among others struggled, namely whether a cultural or endopsychic view of memory is more appropriate for our particular

purposes, continues to puzzle us and is often mentioned as a classic example of the role of the memory of past events. Originally he maintained that actual infantile seduction, a specific environmental traumatic event, was the source of neurosis. He later (1920) modified this to say that the actual infantile experiences of his patients in regard to sexual matters were not necessarily different in essentials from the norm. (He now put primary emphasis on the role of repression in producing neurosis.) He concluded that the history of infantile seductions reported by his patient were in fact fantasies and protected the child from the memories of his own sexual roles and actions. Interestingly enough, while he offered no validatable data to sustain one or the other view, the change in his theoretical position is often quoted by his opponents to belittle him —as if the second version had been validated! Within the therapeutic context, his shift from the cultural to the endopsychic frame of reference was fortuitous. From then on attention was centred upon the patients' modes of dealing with the actual event, his experiences and his techniques for incorporating it. The patient was henceforth envisioned as an active, dynamic unit capable of change, rather than as a passive receptacle of the buffets of fate.

The more specific question of the nature of childhood amnesias and of screen memories has an important bearing upon the matter of the validation of past events. Freud, in his consideration of screen memories, emphasized the repressive nature of amnesia while, for purposes of contrast, Schachtel (1949) is a good representative of those who have stressed the cultural origins of such amnesias. The relevance in the present context has to do with the credence we can or cannot place on the actuality of the remembered event. The concept of screen memories has been a most useful dynamic formulation. For some reason, however, its original meaning has been modified in common usage through the years to mean that the screen memory and that which it conceals are of a more than psycho-

logical significance but constitute actual specific events. The term screen memories was introduced by Freud in 1899, to describe certain defensive operations by which memories of apparently little significance represented displacements and modes of concealing memories of far greater emotional significance. In his paper on that subject (1899) there are several interspersed comments, not particularly relevant to his main theme which bear on the present topic. Thus, he states, 'There is in general no guarantee of the data produced by our memory' and, 'It is very possible that in the course of this process (the means by which a repressed phantasy makes contact with a memory trace) the childhood scene itself undergoes changes; I regard it as certain that falsification of memory may be brought about in this way too'. With some astuteness he indicates where memories have been falsified but the second version, however more convincing in the psychological and therapeutic sense it may be, can lay only limited claim to coincidence with the actuality of past events. Thus he closes with: 'It may indeed be questioned whether we have any memories at all *from* our childhood; memories *relating* to our childhood may be all that we possess. Our childhood memories show us our earliest years not as they were but as they appeared at the later periods when the memories were aroused. In these periods of arousal, the childhood memories did not, as people are accustomed to say, *emerge*; they were formed at that time, and a number of motives, with no concern for historical accuracy, had a part in forming them, as well as in the selection of the memories themselves.'

Schachtel (1949) discusses the normal amnesias of childhood and postulates that the culturally imposed categories of memory available to the adult are not suitable vehicles for the experiencing of childhood memories. He maintains that the modes of experiencing of childhood are only minimally available to the adult and that this accounts for the great bulk of normal adult amnesia of childhood

events. While he mentions the amnesia of repression, this is marginal to his central thesis. Thus even when childhood events can be absolutely validated this is not in itself proof that they will be of psychological meaning and value to the adult since the forces of repression are supplemented by the differing modes of experiencing in child and adult. He stressed the stereotyped modes of reporting prior events common to the adults in a given culture with its emphasis on the culturally acceptable. Events are not only reported in this manner, they are perceived and experienced in this manner and on looking back at one's own prior experiences they are subject to this same process.

Freud's later writings include a further statement on the question of reconstructions in which he again emphasized the importance of the memory of events rather than the actuality of events in therapy. Thus he states (1937) '...the path that starts from the analyst's constructions (reconstructions) ought to end in the patient's recollection; but it does not always lead so far. Quite often we do not succeed in bringing the patient to recollect what has been repressed. Instead of that, if the analysis is carried out correctly, we produce in him an assured conviction of the truth of the construction which achieves the same therapeutic result as a recaptured memory. The problem of what the circumstances are in which this occurs and of how it is possible that what appears to be an incomplete substitute should nevertheless produce a complete result...all of this is material for a later enquiry.'

Since then, the question of the importance of the validation of reconstructions has been taken up by others. Thus, Reider, in discussing a specific reconstruction associated with therapeutic progress, states (1953): 'One last point should be remembered. It is now justifiable to ask whether the reconstruction has actual validity as an event, or whether it is a condensation of a set of circumstances within the conditions of the particular time in the patient's life.' And a bit later, '...most of

the patient's symptoms could be shown to be derived out of either the truly actual past events (the reconstruction) or the childhood situation (as represented by the reconstruction). Either one or the other is true, or both. To argue the point further would be only spurious and tendentious, since interpretations and reconstructions are at best but approximations.'* In effect he dismisses the issue as an irrelevancy.

Several years later, Rosen (1955), reintroduced the idea that the validation of a specific event may be of importance even in therapy. He describes a case where the reconstruction of mother's attempted suicide during the patient's third year is substantiated when the patient confronts his father with it. Father's prior denial seemed to be an important factor in the patient's illness. He comments on Reider's discussion of the importance of the actuality of the event and then states: 'In this paper the formulation offered, unlike Reider's, would tend to assert that, at least where the symptom of derealization is concerned, the question of the actuality of the reconstructed event is of more than academic importance.'

That the subject remains of great interest is illustrated by the more recent paper of Ekstein & Rangell (1961). They offer cautions against rash reconstructions and recommend the empirical study of children (direct observation) and clinical experimentation to validate theoretical positions. They are more clear about what to be wary of than in what to accept in a given patient. In fact, at one point the comment is made that a given reconstruction was 'confirmed by several memories' of the patient. Unfortunately, they do not attempt to further spell out the conditions for validation of any given historical event.

In the above brief review of some relevant contributions to the nature of the process of memory and thus of history, certain issues were emphasized. First, the question of the

* Underlined by author.

importance of the external event as opposed to the endopsychic experience of the event; secondly, the influence of the adult state both in its repressive aspects and in respect to the unalterable characterological changes pursuant to maturation as influences on memory; and last, the question of whether the validation of reconstructions as specific events is or is not of major importance in psychiatry and psychoanalysis.

It should be made clear that what is under examination in this paper is not the validity of the experiences as experiences or of the memories as memories. The specific matter under consideration here is when and under what circumstances such experiences and memories can, with some finality, be said to coincide with external reality—with actuality. For the purposes of this study prior events will be assumed to have a specific pattern. It is self evident that the same event will be perceived and experienced and hence reported in different fashions by the various participants. This is even more particularly true of the affect-laden events which the patient brings to the treatment situation. Nevertheless, a common-sense view dictates the assumption that such prior events have a kernel of specific facts which will be referred to as the actual event. Another arbitrary ordering of events commonly used in psychiatry will be employed. The recent and remote past will be referred to as somewhat different sorts of events. This has the virtue of a certain degree of naturalness, as witness the consistent order of diminution of memory in such organic brain conditions as are observed in the senile. It is common practice to consider the very recent past, today's events, as current and to omit thinking of them in historical context. However, anything which we think about, including the moment just past, is an historical event and will be so considered here.

While superficially it would appear that a view of history based exclusively on the memory of the patient would meet all of the needs in the psychiatric and psychoanalytic

context, such proves not to be the case. There are instances where the determination of whether a past event actually did occur becomes a matter of critical importance. For instance, a college student reports that the other fellows in the dormitory are calling him a 'fairy' and bounce a ball against the door of his room every evening. The matter of whether his peers are actually carrying out these acts is of major importance; are these reported events actually occurring, and are they thus a measure of the young man's accuracy of perception or are they projections and thus a measure of possibly profound mental illness?

It is not only in such instances as the above, where potentially paranoid mechanisms are in process, that the therapist has occasion to be concerned with the actuality of events. An example of quite a different area where the therapist may choose to attempt to ascertain the actuality of events is the following one. In a severe neurotic depressive state a patient reported that his income had dropped sharply during the past few months. The therapist attempted to explore this incident from the standpoint of the over-reactive nature of the depressive response, the veiled guilt, and, so on; but met with no success. Finally he insisted, against some resistance on the patient's part, that he total his receipts for that period of time, and the patient reported that no decrease in income had occurred. Only then could the dynamics of his depression be explored.

The above examples raise a series of questions relevant to the therapeutic process quite aside from the matter of the patient's particular inner experience of the remembered event.

(1) When does the actuality of events become a matter of prime importance to the therapist?

(2) What does he accept as sufficient validation of such events?

(3) What degree of conflict is there between the search for validation for its research possibilities and the therapeutic process?

(4) Is there a difference in orientation between attempts, in the therapeutic situation, to validate the actuality of events in the recent past as opposed to the distant past? If so, where is the cut off point?

(5) In using the principle of the credibility of the reported events as some measure of their actuality are we not using a screening device to exclude many possibilities which could not have occurred?

(6) Can the therapeutic situation itself be used as an instrument to measure the actuality of events other than itself?

(7) What are the common pitfalls in attempting to validate historical events?

This paper will limit itself to some comments on these questions since, in truth no complete answers are available to them.

As cited above in the examples of the bouncing ball and the distortion of financial receipts, the degree of accuracy of the reporting of validatable events can be a matter of major importance. What general principle makes for this assumption? Why can we not simply say that the given version is plausible or not plausible, concur or not as the case may be and let it go at that? In my previous paper (Novey, 1962) certain specific instances were cited where it was felt that this principle applied. There are, however, certain states where the normal processes of judgment are felt to be sufficiently impaired as to necessitate the attempt, either via the patient or others, to validate specific events. For instance, in the child, in the psychotic and in such states as somnambulism and other fugue states these conditions clearly prevail. In some circumstances the reconstruction of events from either the distant or recent past require validation. Thus, Rosen (1955) was able to reconstruct an event from his patient's infancy and to suggest that the patient attempt to validate it from his father. As regards the recent past, an incident recently reported to me by a colleague was that of the confrontation of a patient whom he was seeing at a fee somewhat less than his usual one, that

he could well afford the usual fee but had mis-stated his finances. This reconstruction, which proved to be valid, was based upon the demonstrated neurotic tendency on the patient's part to cheat his wife, the income tax people, and so on.

A particularly gross example in which validation for reported events may be sought either at the beginning of or even during the course of a psychoanalysis is that which arises when physical symptoms suggestive of an organic disease process are disclosed. In these circumstances the patient is referred for the appropriate examination, X-rays and other studies in the attempt to validate the history given by him. Thus, during the course of a psychoanalysis an analysand reported (and this is history in the making) symptoms suggestive of a perforating duodenal ulcer. Recourse was had to an internist for *validation* of the suspected diagnosis and further validation was obtained during the following necessary surgery. Curiously enough, when questions of the relevance of validation are being discussed events of this kind which have both a physical and psychological impact are usually ignored.

While one motive for the many humorous anecdotes about psychiatry and psycho-analysis is most certainly resistance, the concealed truth in such humour deserves serious consideration. A recent actual incident came to my attention. A prominent judge telephoned a psychiatric hospital to inquire about a friend of his who was suffering from chronic alcoholism. He spoke to the patient's physician who informed him that the patient suffered from the delusion that he was related to a certain member of the royalty. Of course, such proved to be the case, as was well known to the judge. It would be easy indeed to dismiss this humorous episode and the somewhat caustic manner of the judge as indicative of the typical obtuseness of the lawyer towards the psychiatric point of view. But the fact is that such incidents happen more often than we are always even aware of and the lawyer has wide experience too in attempting to establish matters of fact and in amassing convincing proof to establish such facts.

What would be considered to be sufficient proof in psychiatry and psychoanalysis that the ball had actually been bounced on the student's door and that his peers had called him a 'fairy'? Many of us would be content with an appraisal of the student's character, the presence or absence of supporting evidence in the remainder of the history and, on some occasions, opinions from relatives or potential participants in the incident. The request for more definitive proof would likely be met with the judgement that further inquiry would be redundant, 'obsessional', or even worse. The fact is that little short of seeing the ball bounced on the door or not seeing it when the ball is allegedly being bounced on the door would constitute such proof and the same is true of the alleged verbal assault. It would require the actual proof of the psychiatrist's own senses or of other neutral observers. Opinions from the alleged participants might or might not be trustworthy and certainly the opinions of other non-observers would be of no help in validation. This is a particularly gross sample of an event of the immediate past. If one considers the subtle innuendoes and interplays in even events of the recent past, the possibilities of validating events of the remote past are slim indeed. We are largely dependent on frequently honestly conflicting versions of events which have been differently experienced in the first place and then differently altered in the course of events. In therapy only a limited amount of help can be obtained from the occasional old diaries and other documents of this sort.

Even in otherwise carefully conducted scientific work, certain assumptions about the memory of past events are made that bear on the present topic. Penfield (1961) describes in connexion with the electrical stimulation of the temporal lobe of a series of patients, the following: 'The experiences recalled are chiefly auditory or visual, or else they are combined auditory and visual. Curiously enough, there are no examples of recall of a

time when the individual was devoting himself to his own action—no example of a time of eating, or of sexual experience, or of concentrated reasoning, or running a race or singing, or playing the piano. There are many examples of hearing complicated music, sometimes accompanied by *seeing the scene in which the music was originally heard and feeling the emotion that it produced*.'* In another publication (1950) he discusses a memory of an event which allegedly occurred 7 years before. At the time of examination the patient was 14 years of age. This event is presumed to be corroborated by the mother's memory of the reporting of the incident and by the patient's two brothers (age unstated) witnessing the event and their recall of it. It need hardly be said that any incident is liable to false consensus and particularly so an event of 7 years before when a girl of 7 is alleged to have been approached by a man stating 'How would you like to get into this bag with the snakes?' This represents one of a great many reported cases, and for the most part no validation of any sort is offered for the alleged events.

That these patients reported extensive experience is unquestionable and that some of them were experienced as recall of prior event by the patient is clear. What relevance they may or may not have had to prior actual experience is a subject unto itself and would be much more difficult to validate.

Several studies of a statistical nature in the more specifically psychiatric field have thrown a degree of light on the characteristics of memory and on the complexities to be dealt with in dealing with the matter of recall. They aim to prove certain general theses related to recall which might well be useful in the *general theory* of memory phenomena. Unfortunately this very principle limits but does not deny their usefulness with the individual patient. The conclusions must inevitably have a degree of generality which prevents their direct use to validate the memories of any given patient.

* Italics by author.

If successful, they will provide more accurate generalities to substantiate or substitute for the ones we are presently employing and this itself is no small accomplishment.

Haggard, Brekstad & Skard (1960) interviewed mothers before the child was born and reinterviewed them at several fixed periods for the next 7–8 years. Some of their conclusions seem obvious to us, others less so. The mothers' anamnesis did not reflect their earlier experiences and attitudes so much as their current picture of the past. Anxiety at the time of the interview served to distort the accurate recall of many experiences. However, anxiety at the time of the past experience seemed to facilitate recall. What the informant says depends in part on the relationship between him and the interviewer and by how the questions are phrased by the one and interpreted by the other. The length of the time interval, by itself, was not meaningfully related to the reliability of the anamnestic reports.

In another study by Goddard, Broder & Wenar (1961) a series of mothers upon whom adequate clinic records were available were interviewed 5–6 years later in connexion with such elementary facts as the duration of gestation, etc. They found that some kinds of history such as the duration of nursing are apt to be grossly distorted while other kinds of information such as the increments of weight at various periods are accurate. In this preliminary study no conclusions were offered but some suggestive findings were reported including the fact that almost one-half of the major illnesses that the child had had were not reported. An earlier study (MacFarlane, 1938) had arrived at very similar results.

Despite opinions to the contrary, in the actual conduct of psychotherapy and psychoanalysis there are many situations where the process of research and of therapy are in conflict. In the attempt to assist the patient to explore the basis for his symptoms and to therapeutically modify them, great emphasis is placed upon the inner conflicts of motivation and of unresolved intrapsychic tensions.

It is his mode of perceiving the world and his means of dealing with it that interests us and we are interested in history only in so far as it throws light on his reactions. The aim is one of understanding history with the patient and to use this knowledge to modify neurotic automatisms. With the emphasis thus placed squarely upon the patient and his experiences, introducing other actual persons of significance into the scene as additional sources of information or even excessive pre-occupation with the issue of validation in the two person situation may well vitiate the basic therapeutic framework. As might be expected, the more serious the emotional disorder, the less disruptive the introduction of other persons will be. This has to do with the fact that the patient's capacity to cope with his problems as a primary intrapsychic process is proportionately reduced and makes for a modification of both the aims and process of therapy.

There are two ways in which the term research is used in the field of psychological medicine that have made for much confusion. One has to do with the exploration with the patient of his intrapsychic processes and, in so far as it has to do with history, of his description of his experiences with others. The other has to do with the attempt to systematically validate the assumptions and hypotheses that may or may not have originated in the first-named process. It is this latter process that is often seriously in conflict with the therapeutic process and here, more than in many other areas of science, the probe may so alter the thing to be examined as to grossly limit the possibilities of validation.

As may be observed in the two studies already cited of the memory of mothers, the requirements of the scientific approach are such as to insist upon the reduction of the number of variables to a number which will allow for the possibility of significant results. Unfortunately, the therapeutic situation is such as to make such studies of ancillary importance but not of critical aid in dealing with the infinite variables which are present in a given patient. The therapist is in this respect rather more in the role of the historian than of the social scientist. Much of what he has to do with is of an irreducible level of complexity and is not replicable. As with the historian, many intelligent assumptions may be made but relatively little absolute proof is possible.

In the usual situation, the opportunities to validate events of the recent or immediate past are greater than for the more remote past. The fact of the possible availability of other witnesses in itself argues strongly for this. Unfortunately, however, it is just the very events of the distant past that are apt to throw the greatest light on the development of emotional illness. The tendency to lay emphasis on characterological development and hence upon the events of the remote past as opposed to the recent acute traumatic event is common to both general psychiatry and to psychoanalysis. The more recent de-emphasis on the reactive type of depression and the increased emphasis on depression as an intrapsychic state, primarily, which is unique to the individual and dependent on his particular modes of dealing with stress are indicative of this trend (Muncie, 1960).

The recall of past events, as has been emphasized by Haggard et al. (1960) is heavily coloured by the anxiety at the time of the interview and by attitudes towards the interviewer and this is the impression one obtains from clinical practice. Unfortunately, however, clinical practice does not lend itself to the proof of this. While it is common for the patient to claim better recall during periods of greater comfort, this is useful in therapy as a measure of his experience but cannot be used as validating evidence. The therapeutic situation itself is a highly emotionally coloured one and the patient is prone unconsciously to conceal and distort historical data for reasons of defence and, sometimes, consciously to do so because of attitudes he may have towards the therapist. The opposite

of this is often the case and the patient may unconsciously supply false data in an attempt to gratify or placate the therapist or for other reasons and 'tell the therapist what he wants to hear.'

The studies previously quoted suggest that certain classes of data tend to be more clearly remembered than other classes of data. This is an intriguing finding, but at least in my personal experience, the clinical situation with individual patients does not clearly indicate any patterning which definitely transcends the possibility of personal bias.

The next matter of interest is the question of whether the credibility of events is not in itself a useful screening device. There are many rational versions of history but not all versions are rational. Were the young man who claimed that his school fellows had molested him to have also stated that they had horns in the middle of their foreheads, this would stretch the limits of credibility and would raise considerable question about the validity of the entire reported event. Unfortunately it is sometimes these additional distortions that tempt us to overlook the considerable segments of accurately reported history which accompanies the distortion. This same issue makes for recurrent critical clinical problems. Thus, the patient with a long history of hysterical conversion symptoms involving one or another area of the body is peculiarly vulnerable to the neglect of even serious organic states since he is felt to be an unreliable informant. It is sometimes a difficult clinical problem in fact to determine when one has to do with yet another conversion symptom and where the symptom constitutes actual physical organic disease. To determine when an adequate physical examination must be insisted upon and when it would represent a manoeuvre that would simply reinforce the tendency to conversion is often a tantalizing issue.

I recall one occasion in which the patient actually felt compelled to protect himself against the assumption that he was hallucinating. A depressed man who had ground privileges in a mental hospital near Baltimore, where alligators are not a common part of the population, observed a small alligator in a nearby wooded area. Knowing that if he returned to the hospital and reported what he had seen, that only one conclusion would be drawn, he captured the animal and brought it back to the hospital. Evidently someone had brought it back from a more tropical climate and, when it grew too large had released it in the woods. While the actuality of distortions of sensory experiences is not being questioned, constant alertness is necessary to ascertain the possibility of the actuality of reported events of even the most psychotic of patients.

Since we have actual experiences with our patients, the question naturally arises as to the degree to which the credibility of the patient's reporting may be calibrated on the basis of experience with him, and this principle will be considered along with some common sources of error in the use of it. In clinical practice a consistently constructed life's history offers valuable clues as to character development and probable modes of experiencing life and of behaving. Also, some useful cues may be obtained from disparities and omissions in the history as well as from what seems consistent in it. Thus, the omission of a period of time in the history for which no memories are available is clinically suggestive of some event or events of significance that are omitted for one reason or another. It must be emphasized that such a clinical suggestion is not a rule, but is a clue to possible lines of inquiry which may be profitable. It is suggestive but in itself proves nothing.

In the therapeutic situation the therapist has the opportunitity to appraise the validity of prior events he himself has experienced with the patient. Through his own immediate experiences he has the opportunity to appraise the patient's ability to communicate at least more recent historical events and this is, to a degree, a measure of the patient's capacity to accurately describe experiences with persons

other than the therapist. This is by no means an altogether trustworthy guage since not infrequently the patient may be grossly more disorganized in the treatment situation than in other situations or vice versa and this may make for an accordingly wide disparity in his reporting of events. Certainly every therapist has had patients who present essentially psychotic symptomatology in the consultation room and who at the end of a session will almost physically pull themselves together and go out to present a not unusual picture in their other human associations. Accepting the above limitations, however, particularly in prolonged treatment, the therapist is aware of a broad spectrum of personal experiences with the patient and, on the basis of this, he establishes some estimate of the reliability of the patient as an informant. In the therapeutic situation it is common to observe wide fluctuations in the patient's memory even about a specific historical event, this being dependent on the level of anxiety and the concomitant character of the defences at any given time. But, as treatment progresses a more consistent and probably more accurate version of history is established.

As has been previously emphasized, no actual historical event can be viewed as being divorced from the meaning of the event as an incident of greater or lesser significance in the patient's life. Particularly in view of the great difficulty in securing validation for any such event, certain common errors in assigning meaning deserve mention. Perhaps one of the commonest sources of error is that of overlooking the plurality of causes for any historical event. While it is true that some causes have a greater degree of relevance than others, it is a matter of particular importance not to simply embrace a specific cause. This should be done in a particularly circumspect way if it is a cause which fits neatly into one's preconceived theoretical notions. This inevitably makes for the neglect of alternate possibilities and the neglect of subtle differences between apparently similar

events. The matter of multi-determination of causes sometimes disposes to a particular dilemma in psychoanalysis where this is a formalized concept (Waelder, 1936). This theory is of considerable value but readily lends itself to misuse since it can be used to defend a closed theoretical system. In that instance if, for instance, one of a series of fixed theoretical views is found to be inapplicable as an explanation, another of the same series is invoked. While lip service is given to multi-determination the view is invoked that one or another member of the series is the principal cause and the complex structuring of causality is essentially rejected. This is well illustrated by the sharp difference between the classic and the cultural schools in psychoanalysis where each group rejects summarily the claims of causality of the other and, likely, some truth rests with both.

Another common source of error is the failure to envision an historical event in a chain of continuity, and instead to view it as a first cause. This may occur not only in connexion with verbally reported events but also in connexion with events actually observed. If one observes a patient strike another this is an actual event but may be of limited meaning unless, for instance, one knew that it was in response to a prior unseen assault. Even in the two persons therapeutic situation, no doubt some share of the patient's positive or negative behaviour towards the therapist constitute events which are responsive to the therapist's behaviour which, even in the best of circumstances, is only partially consciously known to the therapist himself. Thus some aspects of historical events can always be said to have antecedents which one can only know more or less about but never know in their entirety. It is frequently the case, and particularly where the opportunities to validate events are minimal, to resort to reasoning after the fact. Much of the reconstructions of the history of the factors making for emotional disorder must suffer to a greater or lesser degree from this fallacy since

there is no possibility of replicating the precise circumstances leading to this particular person's emotional illness. The best we can hope to do is to keep this factor minimal.

When it is the therapist's appraisal that the distortions of the patient are consistent with community attitudes, and are thus no more than commonly held prejudices, it is his judgment that they do not in themselves suggest emotional disorder. Needless to say, in some circumstances such attitudes may become the vehicle for the expression of personal emotional difficulties (Novey, 1957). An example of a potential distortion of past events based in prior history is that of the patients history of particular attitudes he has experienced toward members of a minority group commonly looked down upon in a given community. In these circumstances the therapist may find the given attitude of little importance in connexion with the present illness of the patient. That is to say that the therapists role is something other than that of the champion of non-prejudicial opinion.

If the distortion of past events is considered to be unique to the individual, not altogether plausible or, as suggested above, common to the social group but overweighted by the patient, then the stated past events out of which they are alleged to have arisen become subjects for exploration in treatment. In these circumstances the therapist maintains that they may be causal factors in the present disorder. Unless great care is exercised the prejudices of the therapist may be substituted for those of the patient and a consensus may be arrived at with the patient on the basis of this new system of prejudices. It is here that the attempt to actually reconstruct the precise nature of past events and not simply a plausible version of them becomes a matter of the first importance.

SUMMARY

In certain instances, determining as accurately as is possible whether a given event actually transpired becomes a primary matter in psychiatry and psychoanalysis. While the matter of the memory of past events and their re-organization in therapy is always important, this is based in actual events of which it is important for the therapist to remain cognizant. While such events can never be totally re-examined, a careful study of the available evidence gives useful hints as to the characterological nature, modes of defence and sources of emotional difficulty from which the patient suffers and is important in determining the therapeutic approach to the patient. The therapist depends upon his general knowledge of the way people usually behave as well as upon his intuitive sense about a particular patient as aids in the reconstruction of the probable course of events in the patient's life. In such reconstructions, as is appropriate and in fact inevitable, he is influenced by his particular point of view and his interests as a therapist. That the means of actual validation of prior events are limited should be recognized but this by no means vitiates the importance of attempts at such validation, where appropriate, or of a historical approach to treatment.

REFERENCES

EKSTEIN, R. & RANGELL, L. (1961). Reconstruction and theory formation. *J. Amer. Psychoanal. Ass.* 9, 4, 684–97.

FREUD, S. (1920). *A general introduction to psycho-analysis*, p. 323, N.Y., Garden City Publishing Co.

FREUD, S. (1898). My views on the part played by sexuality in the etiology of the neuroses. In *Collected Papers*, vol. 1, p. 279. London: Hogarth Press, 1947.

FREUD, S. (1937). Constructions in analysis.

Collected Papers, vol. 5, pp. 358–71. London: Hogarth Press.

FREUD, S. (1899). Screen memories. In *Standard Edition of the Complete Psychological Works of Sigmund Freud*, vol. 3, pp. 303–22. London: Hogarth Press, 1951.

GODDARD, K. E., BRODER, G. & WENAR, C. (1961). Special article—Reliability of pediatric histories, a preliminary study. *Pediatrics, N.Y.*, 28, 6, 1011–18.

HAGGARD, E. A., BREKSTAD, A. & SKARD, A. G.

(1960). On the reliability of the anamnestic interview. *J. Abnorm. (Soc.) Psychol.* **61**, 3, 311–18.

MacFarlane, V. W. (1938). Studies in child guidance. 1. Methodology of data collection and organization. *Monogr. Res. Child Develop.* 3, no. 6.

Muncie, W. (1960). Clinical importance of overt and hidden depression. *R. I. Med. J.* **43**, 2, 95–9.

Novey, S. (1957). Utilization of social institutions as a defence technique in the neuroses. *Int. J. Psychiat.* **38**, II, 82–91.

Novey, S. (1962). The meaning of history in psychiatry and psychoanalysis. *Brit. J. Med. Psychol.* **35**, 263–71.

Penfield, W. (1961). Twenty-sixth Hughlings Jackson memorial lecture. *Med. News*, **17**, no. 14.

Penfield, W. & Rasmussen, T. (1950). *The Cerebral Cortex in Man*, pp. 164. New York: The MacMillan Co.

Reider, N. (1953). Reconstruction and screen function. *J. Amer. Psychoanal. Ass.* **1**, 3, 389–405.

Rosen, V. H. (1955). The reconstruction of a traumatic childhood event in the case of derealization. *J. Amer. Psychoanal. Ass.* **3**, 2, 211–21.

Schachtel, E. (1949). *On Memory and Childhood Amnesia. A Study of Interpersonal Relations*, pp. 3–49. Ed. P. Mullahy, New York. Hermitage Press.

Waelder, R. (1936). The principle of multiple function. *Psychoanal. Quart.* **5**, 45–62.

Perceptual development and childhood psychosis

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A number of recurrent themes appear in the literature on childhood psychosis, sometimes under the heading of diagnosis or clinical description and sometimes in discussions of psychopathology. These themes are variously related to distortions of or preoccupations with one or more of the sensory modalities; to body image disturbance and faulty awareness of the self or of others and with a characteristic desire for sameness of objects and environment, and repetitiveness of movements. It is suggested in this paper that these abnormalities are different facets of a basic underlying perceptual disturbance. It is further hypothesized that normal perceptual development proceeds in an orderly hierarchical manner and that failure of such orderly progression may lead to psychotic perceptual maldevelopment.

Distortions of perceptions and preoccupations with sensory modalities

Abnormal perceptual development has been described by a number of writers. Bridger (1961) by testing infants under 5 days old found differences in the basic sensory capacities and considered that this was connected with the unusual discriminations and preoccupations found in the psychotic child. Fish (1957) describes these children as 'foetal infants' and writes of their 'fundamental pathological symptomatology' which is characterized by retardation or precocity of perceptual development.

Distortions of perceptions and preoccupations with sensory modalities are discussed by Despert & Sherwin (1958). They talk of the

psychotic child's early sensitivity to noises or the absorbed interest in lights or music but difficulty in achieving a smiling response; the failure to follow the mother with the eyes and the lack of anticipation of being picked up. These children show an emphasis on touching, mouthing and interest in textures rather than in the object itself, also bizarre behaviour and gestures and endless hyperactive motor play.

Goldfarb (1956) describes the decreased use of distal receptors and the emphasis on contact receptors with touching, mouthing and smelling. Such 'receptor preferences' found in schizophrenic children could not be explained by sensitivity at the peripheral levels. He thought that the difficulty was an alteration in the hierarchy or preferences and relationships or sensory modalities at a higher level of integration or organization of the central nervous system. Improvement in these children coincides with visual and auditory awareness.

Body image disturbance and faulty awareness of the self and of others

The difficulty that psychotic children have in developing self-awareness has been explained as a 'lag in maturation' where there is difficulty and anxiety in identifying their own bodies (Fish, 1957). Bender & Helme (1953) also hypothesize 'a disorder in the maturation of basic behaviour processes. Particular neuro-physiological systems develop, but the utilization of these skills in the service of the whole organism is impaired. Self-perception is distorted as a result of this primary dysfunctioning.'

These children show disturbance of ego boundaries and identity, bodily dependence on an adult and motor compliance (Bender,

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1947). The problem of self identity is also considered by Goldfarb & Braunstein (1958) when describing the reactions to delayed auditory feedback: 'Schizophrenic children attend less, so are disturbed less by auditory feedback.' Because of aberrant receptor and self-monitoring processes their own voice is not recognized as their own.

Related to the problem of self awareness is that of object relationship. Many authors describe the inability of these children to make normal contact with people. Goldfarb (1956), for instance, talks of 'the clinging to the warm body and not to the person'; of interest in food but not in its preparation; and the exclusion of outer experience by preoccupation solely with the self. Creak (1951) describes these children as living in a world of their own, they cling, but without normal affectionate response.

Mahler & Elkisch (1953) say that these children show 'no awareness of a separate individual entity'. Or again they are described as having an inability to cope with the 'separation-individuation phase'. The symbiotic dependence on the mother is said to result from this inability to form integrated images of the self and of the mother (Mahler & Gosliner, 1955).

Repetitive movements and preoccupation with sameness

Bender (1947) describes the constant rhythmic activity, the whirling and pivoting and the darting movements of these children: 'The schizophrenic child of three to five or six years may become largely preoccupied with motor play which is composed of many interrevolving systems of reflex activity.'

Kanner (1943) considers preoccupation with sameness as one of the cardinal features of early infantile autism. The child may be fixated on one kind of object relationship such as round objects which can be spun like a top, or a desperate need may be shown to keep 'sameness' in the arrangement of toys, furniture, play patterns, etc. Cappon (1953) adds to this description by referring to the psychotic child's absorption in detail, apparently ignoring the total object. Endless repetitiveness is also mentioned by Mahler & Elkisch (1953) when discussing disturbed ego functioning in psychotic children.

Despert & Sherwin (1958) describe similar aspects of the psychotic child's symptomatology. There seems a need to adhere to rigid routines. There is solitary repetitive play and rocking, an intense insistence on sameness and a constant spinning of objects or tearing of paper.

Preoccupation with sameness, or the use of objects for other than their intended purpose, though at times much like obsessional ritual, can be seen as an expression of a more primitive disturbance. Where this is so, the same object or the same activity may provide islets of security within the confusion of meaningless stimuli, and as such is reminiscent of the in-between world of the transitional object (Winnicott, 1958). Such repetitive activity or 'sensory play', might also be regarded as a primitive kind of auto-erotic activity and thus must be differentiated from the complex symbolism of the obsessional ritual. It should be seen as an attempt by the psychotic child to master incoming stimuli. Thus unusual motility can be seen not only in 'sensory play', or as the accompaniment of the unusual use made of objects, but also as a primitive over-employment of the kinaesthetic relative to the other sensory modalities.

We consider that the concepts of body-image, and self and non-self, represent perceptual experiences of different kinds and complexity and thus depend on the level of perceptual development. Equally, object relationship requires an awareness of self as distinct from others and as such demands normal perceptual functioning.

Clinical evidence of perceptual disturbance

In the psychotic child the inferred failure in object relationships and of self non-self differentiation as well as abnormal motility patterns is paralleled by observ-

able disturbance of the utilization of the distal modalities.

An example of apparent non-use of vision is illustrated by Sam who up to 3 years would never walk without holding on to pieces of furniture or touching a wall. Rather than making one or two steps unaided across a 'gap' he would move all along the wall to get to the desired place. At this age he blinded himself for 3 days by putting lanoline into his eyes. This did not seem to upset him at all and he went about the house quite as well as when he was able to see.

Avoidance of the spoken word was shown by Alan who not only appeared at times not to hear but expressed his attempt at avoidance by saying agitatedly 'Don't say that—don't talk to me' and who at times stopped his ears with sand and gravel in his endeavour not to hear.

Some children not only avoid looking at people but also at themselves in the mirror. Max would spend many minutes standing in front of a mirror fingering the glass with his head turned away. He also developed a remarkable skill of flicking little paper balls at people without apparently looking at them. Severe withdrawal was a feature in all of these children.

Charles was another child who spent much of his time isolated with bizarre posturings and strange little movements. Slowly he took more notice of the member of the staff who looked after him, gradually seeking her company and responding to her. As this was happening he became increasingly interested in his mirror image, which he had anxiously avoided up till now, and he spent a good deal of his time scrutinizing himself and his movements in the mirror.

Early preoccupation with sight and sound is another feature of unusual perceptual development. Despert & Sherwin (1958) describe the absorbed interest in light and music during the infant's first year. In our own experience there is Tom who, at the age of 12, had practically no spontaneous speech, who had no scholastic attainment and whose

relationship with other people was minimal and, where present, associated with extreme anxiety and buffoonery. But in his second year his diction and vocabulary were greatly advanced. He 'knew' so many advertisements in buses that people wondered if he could read. He could say the alphabet and count to fifty. He knew the titles of about a hundred books in his father's library and would pronounce faultlessly, such words as Saggitarius, Andromeda and Nebulae.

The over-emphasis on proximal sensations of touch and smell is another of the characteristic features of psychotic children. Max at the age of 8, would finger objects, and sometimes people, up and down with rapid flicking movements. At intervals he would flick his fingers back and forth between the object he was exploring and his tongue and lips as if he needed the confirmatory evidence that comes from mouthing.

This attempt to explore by touching and mouthing is also seen in Mike's behaviour. He noticed the imprints he made in the snow and picked up the snowy footprints and put them to his mouth. Later he knelt down at a puddle apparently looking at his reflexion and put his lips to it.

Some children who show little interest or awareness of the world around them seem to recognize and associate people and places by their smell. Alan who had been at High Wick for a few weeks and then returned to it after many months absence, stood in the fore-court on arrival, sniffed and said 'smell'. When the teacher used a different brand of soap one day, two or three of the children sniffed her up and down to 'recognize' her.

Robert, when going through a phase of showing interest in various objects, 'discovered' doors. He spent a day or two smelling the doors, licking them, then wetting his finger, rubbing it on the door, then tasting it. After these preliminaries he drew doors from all angles.

Over-activity or aimless activity can be seen as motility unintegrated or unchecked or unharnessed by later modalities. It has been

observed (Burlingham, 1961) that only in the sighted child does the toddler's movement become one of 'agility, competence, security, rhythm and grace of movement'. Unless one confuses 'agility' and 'competence' with the reckless abandon of the psychotic child based on absent or diminished awareness of real danger, one finds that he too lacks these attributes of movement.

Sensory play could be seen as an attempt to render meaningful the incoming stimuli. It represents a continued attempt to link movement, touch, sight and sound. It is a normal feature in infancy (Hoffer, 1959), but an example of arrested perceptual development in the psychotic child.

Here it can appear as experimentation with movement and vision (finger play) or of movement, feel and seeing in the endless pouring of sand and water or as experimentation of movement, feel and sound by tapping objects against the ear.

Burlingham (1961) reports the observations of mothers of blind children 'that their infants do not seem to have spontaneous pleasure in feeling objects with their hands except those that make a sound'. This may confirm that sensory play is a continuing attempt to make sense, an attempt given up by the blind child. The psychotic child can see, his blindness is perceptual, thus his attempts to make sense are not given up.

Preoccupation with sameness is sometimes analogous to sensory play and is thus an attempt at mastering of incoming stimuli. It also represents by its very repetitiveness islands of security in a world of largely meaningless confusing stimulations. Amy, aged 5, would endlessly and skilfully kick a tin or similar object along the floor. If accidentally this object hit another, she would pick it up and put it to her mouth. The kicking to and fro was accompanied by simultaneous flicking of hands and a constant monotonous humming. This kicking stopped after many months when she began to form a trustful and responsive relationship to her nurse.

One of Joey's main occupations was tapping sticks against one another. These had to be of equal length and she would therefore favour objects like knitting needles or spoons. If, however, she used straws or sticks she found on the ground she would carefully break the longer one to make a pair of equal length.

Body image disturbance in the psychotic child can be inferred by his unusual or bizarre drawings, clumsy movements or in the exploration of the body in an apparent attempt to fill in the gaps in the incomplete image.

Sam 'discovered' his stomach by putting his hands down the neck of his shirt as well as by his usual method of putting his hands up the front of his shirt.

Sensory deprivation and perception

Further evidence that perceptual dysfunctioning may lead to the kind of disturbances described comes from research into sensory deprivation. Here the disturbances are not due presumably to any inherent limitation of the perceptual apparatus but to the partial or complete absence of such external cues as are necessary for normal perceptual functioning.

Although disturbances in all sensory modalities were described, distal modalities seem particularly affected, and body image disturbances were vividly described (Bexton, Heron & Scott, 1954; Smith & Lewty, 1959). One subject felt as though his head was detached from his shoulders. Another felt his arm to be heavy as a ton weight and fatter than his body. Bexton et al. (1954) also reported the occurrence of visual and, more rarely, tactile hallucinations.

Also relevant may be the reports by various authors of the effects of sensory deprivation on animals. Freedman (1961) found that with monkeys and kittens, a deficient early sensory environment made subsequent development difficult and sometimes impossible. Riesen (1961) noticed the occurrence of perceptual arrest in kittens. In some instances this arrest was reversible but in others it led to persistent perceptual and learning deficits.

PERCEPTION-SENSATION

A sensation can be defined as 'an activity of receptors and the resulting activity of afferent paths up to the cortical sensory area' (Hebb, 1958, p. 179). Such a definition would include the exteroceptive and proprioceptive systems, but would exclude the enteroceptors as their central connexions are uncertain and they have no clearly defined cortical sensory representation.

Any physical or chemical changes in the environment which reach a certain threshold will produce physiological changes in the appropriate receptors. These changes may or may not give rise to an observable behavioural response. In its simplest form, as in the case of the unconditioned reflex, the response is immediate and predictable, following on the stimulus-produced sensation.

Many behavioural responses in men do not immediately follow the stimulus, and are not clearly predictable. Furthermore, under certain conditions, the same sensory input may be experienced differently, or may give rise to different types of behaviour. Conversely different sensations may produce the same experience or behavioural response. It seems, therefore, that the simple formula of stimulus-response is not sufficient to explain behaviour, but that there must be processes in between the stimulus and response that mould the incoming sensations. Behaviour could, therefore, be considered to be 'under the control of sensory events plus mediating processes' (Hebb, 1958), or one can define perception as 'the mediating processes to which sensations give rise directly' (Hebb, 1958). In that sense also, perception can be considered as preparatory to the behavioural response.

Behaviour which is sensory dominated will be more directly and immediately under environmental control; behaviour which is modified by attitudes, expectations, experience or by what Hebb would call 'the mediating processes' will be more adaptable, less rigid and will provide the individual with the subjective experience of meaningfulness.

Hebb (1958) tries to explain the formation of these mediating processes in terms of build-up of sensory experiences: 'Sensory stimulation arouses a central process which occurs only when that stimulation occurs; but with repetition the central process changes, becomes internally organized, so that it is capable of an independent existence. Now it may continue after the sensory input stops, or it may be aroused in the complete absence of the originally necessary input by connexion with another central process. The process is autonomous in that it can be detached from the original sensory event....'

The formation of 'cell assemblies', namely clusters of cells which as a group have become sensitized, as it were, by past experience is offered as a neuro-physiological hypothesis concerning the mediating processes. One may add, however, that although such cell assemblies or mediating processes are presumably based on simple sensations, there would seem a qualitative difference between these early cell linkages and the complex patterning in the mature individual. In other words, perception is not just the sum total of a number of complex sensory links.

Solley & Murphy (1960) consider the sequence of events leading to the perceptual act as follows. The impinging of the external stimulus is preceded by a certain expectation which will influence attention. The reception phase leads then to a trial and check, helped by autonomic and proprioceptive feedback. At the same time there occurs a structuring along natural lines such as has been described by Gestalt psychologists.

It seems clear that perceptions are gradually built up out of the sensations of a combination of sensory modalities, and that there is likely to be a continuum in the course of the individual's development from primarily sense-dominated to percept-dominated behaviour. In physiological terms, there will be gradual formation of cell assemblies involving numbers and complexity of linkages. From the viewpoint of psychological theories there is a converging of learning and per-

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ceptual operations. Primitive unlearned perceptual processes undergo moulding, modification, differentiation and integration directed by factors of motivation, reinforcement, repetition, contiguity, etc., to produce structured or patterned behavioural responses. Psychodynamically their development can be seen as a growth from the undifferentiated drive-dominated state to the complex functioning of the reality orientated ego.

PERCEPTUAL DEVELOPMENT

There can be two main theories of the way the individual's perceptual world is developed.

In the first instance, one can assume that one or more of the sensory modality systems are present in the organism from birth, and before, and that they begin to function in a definite order. The individual possesses the potential sensory modalities out of which, with increasing complexity, his world is formed.

The second possibility would be that the individual at birth is in a state of non-differentiation as far as the sensory modalities are concerned. Werner (1948) used the term synaesthesia, meaning a syncretic unity of the senses: 'Synaesthesia does not imply a summation of function, the syncretic function must be understood as a specific phenomenon differing in kind from any of the functions which may emerge from it as the result of processes of differentiation'... 'concrete and affect thinking are...characteristic examples of syncretic activity'. He also says 'In the genesis of so-called sensory discrimination, at least three genetically distinct processes ("analogous processes") must be taken into consideration: discrimination on the motor-sensory affective level, on the perceptual level, and on the conceptual level'. The idea is that individual sensory modes develop out of a more undifferentiated sensory unit, and similarly further differentiation occurs within the modes —for instance, discrimination of colour.

These two hypotheses are similar to the ones postulated for the development of

speech, the one being that speech is formed out of a multitude of sounds from which crystallize out those sounds which then produce the language: the other idea being that speech is built up, brick by brick as it were, from the simpler to more complex sounds (McCarthy, 1954).

In whatever form sensory modalities develop, be it by maturation of a primitive nucleus, or out of a syncretic unity of the senses, one must assume that perceptions, and thus the perceptual world, are built up from sensations. The basic question remains to be answered: how does perceptual development proceed?

The newborn is an organism upon which all manner of stimuli impinge. All these stimuli are responded to—that is, they produce physiological changes at the receptors which in turn produce a conduction along the relevant channels of the central nervous system. There are as yet presumably no or few linkages as the result of previous stimulations that could combine to produce cell clusters. In other words, the stimuli, uninfluenced as yet by factors of motivation, reinforcement, repetition or continguity, are little more than meaningless excitations, though possibly associated with feelings of pleasure or unpleasure.

If there are cell linkages present in the neonate, these may be either constitutional, i.e. primordial cell assemblies possibly representing the inborn behavioural traits discussed by ethologists, or they may be considered analogous to the 'undifferentiated phase' of which Hartmann (1959) speaks. During this phase, there is maturation of apparatuses— which later will come under the control of the ego—that serve motility, perception and certain thought processes. Maturation in these areas proceeds without the total organization we call ego; only after ego formation will these functions be fully integrated. Existing linkages could also be considered the outcome of enteroceptive and kinaesthetic sensations in intra-uterine life. These cell assemblies could thus form the

nucleus for linkages of ever increasing complexity.

If we postulate that there are no cell assemblies present in the neonate then certain conditions must prevail to enable their development. One or more of the sensory modalities must be in a state of sufficient biological maturity for stimuli to be received. The stimuli themselves must be repetitive and of a similar nature. These earliest linkages or 'pre-perceptual' experiences must be associated with the same kind of affect; they must be consistently pleasurable or unpleasurable.

The enteroceptors are under the control of the autonomic nervous system and as such remain reflex and passive throughout life as a constant inescapable background. Because of this very constancy they do not as a rule, under normal conditions, reach consciousness in the mature individual.

Of the modalities which come increasingly under voluntary control, proprioception is ontogenetically the earliest. It occurs from around the twentieth week *in utero*. The kinaesthetic properties of movement are a complex of sensations and their complexity will increase with the feelings of weight and gravitational pull after birth.

The importance of motility for perception has often been stated—for instance 'perceptions are only formed on the basis of the motility and its impulses'...'no perception without action' (Schilder, 1950, p. 15). 'The co-ordination of physical movement in sensory impression is basic for primary form perception'...'the importance of movement in the construction and interpretation of the environment' (Werner, 1948). Thus movement can be considered the precursor and concomitant of all future sensations. Once it has commenced *in utero* it will produce a patterned variation of impinging stimuli.

The sensation of touch is the one with kinaesthetic sensations, which ontogenetically is the earliest in the developing individual. It can only be experienced though after movement has made possible those minimal variations or alterations in stimulation which are the prerequisites for the experience of sensation.

There is a constant impingement of touch stimuli of a very similar kind on the body of the infant; he lies on his back, he is covered except for certain parts of his body—face, hands, feet—he experiences the double sensations of touch and being touched when he touches himself. He soon develops the small measure of motor control that allows him to touch more or less at will, so that stimuli impinge on, say, the hands and feet and by virtue of their repetitiveness may produce the earliest cell linkages, particularly when associated with pleasurable affect. In his daily handling, the mother provides a host of similar and repetitive stimulations. Above all, the touch sensation, which is uniquely repetitive and uniquely pleasurable is the one associated with feeding—that is the touching of the nipple with the lips and tongue and of the breast with the hands. Furthermore, that touch is the first way in which the individual learns to interpret the world is seen by the fact that for many months the infant explores by mouthing; objects are touched and scrutinized by being put to the mouth.

The affect-associated sensations of movement and touch will be primarily responsible for the fusion of cell assemblies and linkages which together form the precursor of the child's image of his body. The perceptual system, based on proprioception and touch, is the basis and the anchor from which the outer world can be measured and understood —that is, distal receptors can only come into action meaningfully as a growing out of the product of the sensations of movement and touch. This does not mean that the distal sensory modalities do not normally take part in the production of the body image, but rather that with the dominance of the distal receptors, the emphasis of the individual's world is shifted from the body to that of the body-in-the-world, that is: the self. When therefore we talk of boundaries (body boundary, self boundary) it might be more appropriate to understand it in terms of

qualities of perception and the limitations or horizons which these different qualities imply.

The self can be regarded as the perceptual world of the distal modalities, a world which the individual experiences with himself as the central point. 'Objective knowledge can only be conceived in relation to subjective....An objective intelligence...being conscious of its own "I" will be able to say what roughly is fact and what is interpretation' (Piaget, 1930, pp. 241–2).

Perceptual development can be seen as a progression starting with the emergence of movement and leading by addition and integration of other modalities in a hierarchical manner to the development of the mature self which is characterized by the dominance of the distal sensory modalities.

At first it is touch, together with the kinaesthetic sensations which are predominant, and form the basis for the evolution of, and then integration with, the distal modalities. It is somewhere at this stage that the body-image is formed. Gradually with the progression of perceptual development there is an increasing differentiation of the distal modalities and a receding and abstraction of the proximal modalities and a shift in emphasis from the body. This abstraction and differentiation are the basis for the growth of the self.

CONCLUSION

The development described could be represented schematically (see Fig. 1):

| Proximal | Emergence of progressive integration of movement and touch *in utero* |
Proximal + (Distal)	Emergence of distal sensations in the newborn
Proximal + Distal	Emergence of body-image and progressive integration of proximal and distal sensations
	Progressive differentiation of the distal and abstraction from the proximal modalities
(Proximal) + Distal	Mature self

Fig. 1

In many instances the basic disturbance of a psychotic child may be a failure to progress in his perceptual development through the sequence outlined above. The integration of the various modalities does not proceed smoothly, that is, there may be an overemphasis on earlier, or more rarely a precocious development of a later modality and a failure to reach the stage of mature self awareness.

The mature self can be considered as the body image in the world, namely, seen through the world of the distal receptors. And it can be expressed as the individual's ability to experience the world through the 'I' as the focal point, 'seeing' and 'hearing' things with himself firmly fixed as the centre of his experiential world. The concept of boundary with its spatial connotation is misleading, and disturbed body image and failure of self and non-self differentiation could better be expressed in terms of qualitative variation or changes of the proximal and distal receptors respectively.

Much of the psychotic child's symptomatology can be understood as an attempt to integrate and therefore make meaningful the impinging stimuli, or it can be seen as an attempt to adapt to the environment with the limitations of the perceptual apparatus at his disposal. To what extent these limitations are due to constitutional factors or early malignant environmental influences remains uncertain.

REFERENCES

BENDER, L. (1947). Childhood schizophrenia—A clinical study of 100 schizophrenic children. *Amer. J. Orthopsychiat.* UDL 117, 4056.

BENDER, L. & HELME, W. H. (1953). A quantitative test of theory and diagnostic indications of childhood schizophrenia. A.M.A. *Arch. Neurol. Psychiat.* 70, 413–27.

BEXTON, W. H., HERON, W. & SCOTT, T. H. (1954). Effects of decreased variation in the sensory environment. *Canad. J. Psychol.* 8, 70–6.

BRIDGER, W. H. (1961). Sensory habituation and discrimination in the human neonate. *Amer. J. Psychiat.* 117, 11, 991–6.

BURLINGHAM, D. (1961). Some notes on the development of the blind. *Psycho-Analytic study of the child*, vol. 16, pp. 121–45. London: Hogarth Press.

CAPPON, D. (1953). Clinical manifestations of autism and schizophrenia in childhood. *Canad. Med. Ass. J.* 69, 44–9.

CREAK, M. (1951). Psychosis in childhood. *J. Ment. Sci.* no. 408, 545–54.

DESPERT, J. I. & SHERWIN, A. C. (1958). Further examination of diagnostic criteria in schizophrenic illness and psychosis in infancy and early childhood. *Amer. J. Psychiat.* 114, 784–90.

FISH, B. (1957). The detection of schizophrenia in infancy. *J. Nerv. Ment. Dis.* 125, 1–24.

FREEDMAN, S. J. (1961). Perceptual changes in sensory deprivation: suggestions for a conative theory. *J. Nerv. Ment. Dis.* 132, 17–21.

GOLDFARB, W. (1956). Receptor Preferences in Schizophrenic Children. A.M.A. *Arch. Neurol. Psychiat.* 76, 643–52.

GOLDFARB, W. & BRAUNSTEIN, P. (1958). Reactions to delayed auditory feedback in schizophrenic children. *Psychopathology of Communication.* Ed. Grune and Stratton.

HARTMANN, H. (1959). *Ego Psychology and the Problem of Adaptation.* New York: International Universities Press.

HEBB, D. O. (1958). *A Textbook of Psychology.* Philadelphia and London: Saunders.

HOFFER, W. (1949). Mouth, hand and ego integration. *Psycho-Analytic Study of the Child*, vol. 3/4, pp. 49–56. London: Imago.

KANNER, L. (1943). Autistic disturbance of affective contact. *Nerv. Child*, 2, 217–50.

MAHLER, M. & ELKISCH, P. (1953). Some observations on disturbance of the ego in a case of infantile psychosis. *Psycho-Analytic Study of the Child*, vol. 8, pp. 252–61. London: Imago.

MAHLER, M. S. & GOSLINER, B. J. (1955). On symbiotic child psychosis. *Psycho-Analytic Study of the Child*, vol. 10, pp. 195–212. London: Imago.

McCARTHY, D. (1954). In *Manual of Child Psychology.* Ed. L. Carmichael. New York: John Wiley.

PIAGET, J. (1930). *The Child's Conception of Physical Causality.* London: Routledge and Keegan Paul Ltd.

RIESEN, A. H. (1961). Studying perceptual development using a technique of sensory deprivation. *J. Nerv. Ment. Dis.* 132, 1, 21–5.

SCHILDER, P. (1950). *The Image and Appearance of the Human Body.* New York: International Universities Press.

SMITH, S. & LEWTY, W. (1959). Perceptual isolation using a silent room. *Lancet*, ii, 342–5.

SOLLEY, C. M. & MURPHY, G. (1960). *Development of the Perceptual World.* New York: Basic Books.

WERNER, H. (1948). *Comparative Psychology of Mental Development.* New York: Science Editions.

WINNICOTT, D. W. (1958). *Collected Papers: Through Paediatrics to Psycho-Analysis.* London: Tavistock Publications.

Case history of a borderline personality

By LUCY P. LIEBERMANN*

The case described in the following paper was referred to me as a 'stammering patient, with moderate character difficulties'. He had registered at the Budapest Psychoanalytic Clinic sometime about 1930. He was placed on the waiting list, and waited for analysis for several years. Since I had been engaged in a research work concerning stammering I was naturally interested in the subject, and thus took the patient on for treatment.

The patient was aged 27 at the time. At our first interview he made a queer impression. He was extremely tall, thin, and very dark. The general effect of darkness was enhanced by the fact, that he wore a trimmed black moustache and dark spectacles. His eyes had a disagreeable piercing expression. He wore a dark suit—was very awkward in movement, rather slow, and both his facial expression and motility were sparse and strikingly empty. His chief complaint was his inability to speak —especially with superiors—but he said there were weeks when he was practically unable to speak to anyone. He complained about being constantly depressed, though he explained his depression almost entirely by his speech defect. he had no social contacts except those his work offered, and these were few and unsatisfactory. He was a house physician at a Clinic for Internal Diseases preparing for a postgraduate degree in Internal Medicine. He despaired of his ability to pass the examination because of his speech defect.

At our first interview I found that whatever his difficulties were in the first instance, he needed motor and phonetical training to ensure some possibility of speech. We therefore agreed that he would take a preparatory

course in speech training in order to deal with his most disabling symptoms. These were: an almost constant cramped condition of the masseter muscles, which practically inhibited the movements of the mandible, a cramped condition of all neck muscles, blurred phonation, arythmic speech and faulty breathing.

In his hereditary make-up there was no history of stammering, migraine or epilepsy but cases of schizophrenia on his mother's side. As a small child he had been left handed but he had been trained to use his right hand. He came from a middle-class family, and was the first child among three— two boys and a girl. The family came of a small landholder class and lived in very regular, but strained economic conditions, in a state of constant organized poverty. He was the only one of the children who had a university education—the parents had not been able to afford it. The father was a humourless, strict person, very much attached to and dependent on his wife. The mother was —according to the patient's description—an impulsive, very beautiful woman, much better educated than the father but somewhat hysterical and labile. The family was strictly religious—though there were some religious controversies—the mother being Protestant, the father Greek Catholic. Consequently the boys were educated according to the Greek Catholic rite, the only daughter being Protestant. These differences were a constant source of friction within the family. The father was passionately attached to his wife, and though outwardly he seemed a despotic *pater familias*, in reality the entire family was ruled by the rather erratic, impulsive wife.

These facts were told by the patient at the initial interview. We agreed that he would

* Budapest.

start his speech training, and after having acquired some easing of his speech capacity, we would start analysis. I agreed to see him from time to time, meanwhile, to see whether he was making any progress. After approximately 6 months of training, during which his speech markedly improved, he complained that his depression and irritability—the latter a new complaint—was increasing to an intolerable degree. We agreed to stop speech training and start analysis.

This analysis continued without interruption for 4 years. It was interrupted by the Second World War and its consequences; it continued from 1946 to 1949, when it seemed to be completed. It had, however, to be taken up again in 1955 and has been going on ever since intermittently—continuously for the last 2 years.

EXTRACTS FROM THE FIRST PERIOD OF PSYCHOANALYTIC THERAPY

At his first session the patient entered the room and seated himself upon the couch with a strikingly awkward movement. Then he stopped for a few minutes, remaining motionless, his arms dropping at his sides, staring before him. Then with a sudden abrupt movement, unlike any other patient I had seen, he lifted his legs and flung himself upon the couch. Then a very long silence followed.

The silence continued. Then as if something had suddenly opened, he started to talk. He was able to speak though often interrupted by his stammering. The subject of the first period of his analysis was almost entirely filled by complaints concerning his present difficulties. These were: difficulties at the Clinic, chiefly with his chief and with the head nurse, a nun; he felt ill at ease; he disliked his work, and was irritable because he had to treat sick people who complained and were in pain; he did not like his profession; he quarrelled with his colleagues and especially with the different nurses, and he quarrelled at home and complained bitterly that nobody liked him.

The first analysis was filled with complaints, concerning actual, everyday events. Gradually there emerged from what he was telling the picture of an extremely irritable, inconsiderate person. He never paused to consider the effects of his own behaviour upon others. He was always looking for offence, was full of grievances, resented every criticism and accepted no interpretation. Another striking feature of his analysis was, that he had no dreams, and no memory of ever having dreamt at all.

Long silences alternated with long extremely aggressive tales of wrongs he had suffered, or imagined that he was suffering. Analysis progressed very slowly, but his stammering, though undergoing changes all the time, seemed to get better in proportion to the amount of aggression that was expressed.

His love life was extremely miserable. He had been in love once before with a fellow student, a very pretty, intelligent girl who had flirted with him and he had a short affair with her. She turned him down rather cruelly—telling him that he was a poor bed partner —and since then he only had passing affairs, always overshadowed by the fear of impotence. In fact, as it turned out, he suffered frequently from ejaculatio praecox, and consequently his sex life gradually shifted towards prostitutes. He considered intercourse and everything connected with it a purely physical affair, and his whole attitude left the impression that he considered it exactly in the same manner as if it was something like defecation. Suggestions, that perhaps more emotion, interpersonal relationships, etc., were involved, were impatiently and very often, aggressively brushed aside.

Even in spite of his precautions to avoid emotional traumata in his sex life and treat it entirely as a purely physical need, his potency began to grow worse. At this period masturbation and intercourse with prostitutes alternated, neither very satisfactory, while his fear of impotence was constantly growing. He became again more irritable, restless and

depressed and his speech got worse. Then on a New Year's Eve at a party he received a homosexual offer—quite openly. His first reaction was rage, the second overt panic, and in his second session following this event he began to produce physical sensations. The first of these manifestations was preceded by a somnolent state, drowsiness, incoherent speech, a sudden increase in size of objects, panic and then a strange sensation of being able to change the size of his body. It started with the feeling of his left hand growing longer and bigger. This feeling began in his fingers, spread to the whole hand, to the forearm, and to the whole arm. It was something like an illusion—because intermittently, while describing it, he stated that he knew that it was not quite real—but he could not stop feeling it in spite of knowing that it was not really so. During the analytic session this sensation spread to his entire body. Accompanying emotions were fear, suddenly changing into an omnipotent feeling. He fantasied that he was as tall as a three-storied house—he was in fact feeling like the king in Gulliver's Brobdignag. He was powerful, strong and could kill everybody, crush me, the inhabitants of the town, the whole country. By the end of the session he came to realize that this sensation had passed, and felt terribly lonely, small and dejected.

In the following session the reverse sensation appeared, that of shrinking, till he was as small as 'Hüvelyk Matyi' (Tom Thumb, a Hungarian fairy tale). He felt vulnerable, endangered, fearful and unhappy. Then, with a sudden abrupt change of mood he turned upon me, called me a sorceress, who caused him to experience such frightening sensations.

This alternating experience—bigness and smallness—continued through many sessions. Gradually, after many repetitions, childhood memories emerged, but always first as accusations in the transference. I was accused of ill-treating him, of cheating him, of seducing and frustrating him. After a series of accusations scraps of memory emerged. First panic, after that the memory of a very severe beating his father gave him, indeed many beatings, causing erection, mostly for having been rude to his mother.

There had been times when he had been on good terms with his father. Later, after another body change illusion, the following memory came to surface: His father was away and he was sleeping in his father's bed beside his mother (the parents slept in a double bed). He woke in the night, feeling that he had an erection (he was aged 7 at the time). He faintly remembered having watched the parents having intercourse quite often (he slept in the same room and always feigned sleep). On that night, still drowsy, he thought he would try to do as father had. His mother tolerated his caresses, even returned them— at least that was how he remembered the situation. Then, when he tried to lie upon her, she pushed him away, slapped his face, laughed at him, told him that he was a naughty little boy, and that she would tell father what he had tried to do. He was paralysed and panic-stricken, humiliated and enraged. He rushed from the room, locked himself in the cold dark bathroom, and stayed there till morning. In the morning he felt 'dead'. He hated his mother and feared and hated his father. He tried to go to confession but was afraid to confess. After this memory had broken surface, the body-sensations ceased.

Instead temper fits, depressive bouts and paranoid constructions emerged. Every new memory, appeared first in the transference situation as an accusation against the analyst. When this was interpreted over and over again, a kind of *modus vivendi* developed between us, so that analytic work continued. The range of emotions displaced on to the transference situation varied between hate, guilt feelings, paranoid projection and, later, love.

As these projections were dealt with gradually new symptoms appeared, body sensations of a different quality. Abdominal pain, headaches, hypochondriacal preoccupations (tuberculosis, cancer—many diseases turned

up one after the other). When interpreted, the interpretations were accepted. His speech became much better, depressive states did not last as long as before, and finally faint positive emotions began to appear. He passed his postgraduate examination, matters at the Clinic were smoother and he chose to remain at the Clinic and study dietetics, that is he chose an oral aspect of Internal Medicine.

Homosexuality continued to be an intriguing but very ambivalent subject. At the time he had a very intimate friendship with a colleague who was believed to be bisexual. His attitude towards his father became openly aggressive; all the repressed anger and hate, all his ambivalent love for his mother and suppressed jealousy towards his younger brother emerged. All these emotional memories always came first in the transference situation, as accusations against the analyst. In the transference situation the analyst became the mother.

At this period there was a positive transference situation. Considering the psychotic features of the case, I thought it necessary to maintain a minimum level of positive transference, for it seemed that if this became impossible further analysis would become impossible too. For months and months the direction of analytic interpretation continued to unravel the interwoven pattern of reality and his persecutory projections.

This brought some relief. At this phase it was possible to analyse the elements of the speech disorder. It turned out that he was never able to enter into direct contact with another person, or be at one with himself. This splitting and oscillating between what he wanted to say and how to say it never left him. In fact this splitting occurred every time when he encountered and tried to establish contact with an internal or external object. Therefore he was never able to express himself as a unity. Always only bits of himself could be expressed in words or deeds, and after having expressed in speech or action a split part of his ego, the relevantly connected,

but split-off part came to the surface as an opposed emotion. He suffered very much from this emotional instability.

At this stage he began to develop states of 'diffuseness'. He was more or less unable to concentrate, forgot important things, became alternately passive and restless, or active or unable to do anything. He blamed the analyst for all these phenomena. She was responsible for everything, in fact for being alive at all. In this period of the analysis it was interpreted over and over again that the analyst represented the mother, his desires and ego had regressed to an infantile stage and that these sensations had to be compared with, and separated from, outer reality. His fantasies were of warmth, sleep, bodily contact and being breast-fed.

As soon as there was some positive transference, the outer life of the patient became more normal. Work continued with less friction. He left his parents, rented a room, and went home only for visits. Consciously, at least, he seemed to accept the fact that his mother was not an extremely evil woman. He tried to start affairs with girls but with very moderate success. These affairs caused him little pleasure and no emotional satisfaction.

He started to get interested in politics. At the Clinic where he worked, intense pro-German and pro-Hitlerite propaganda was going on. He joined these meetings, talked a lot—and even made short successful speeches. He became rabidly anti-semitic. All this political intrigue proved an excellent outlet for his aggression.

In 1941, again on a New Year's Eve, he made the acquaintance of a Jewish girl. She was intelligent, well educated, attractive, though not pretty, and very boyish. She was very active, and started an affair with him. He was flattered, amused, and too passive to resist. The affair attracted and amused him, malgré lui and malgré his brand new anti-semitic principles. Moreover, the entire situation corresponded perfectly with his internal ambivalence. The affair continued and became a very personal relationship,

carried on by the active attitude of the girl. He was caught in a double net, his political attitude and his emotional ambivalence on one side and a charming intelligent very attractive woman who loved him on the other. Then the laws against Jews were issued. He put principles aside and did his best to save the girl. In 1944 when the Germans invaded Hungary and the persecution of Jews really began he hid her in a lunatic asylum and saved her life.

His analysis was interrupted at this stage because of external events. I left the capital and spent the siege of Budapest in the country, only returning in the spring of 1945. There was no communication between the country and the capital, meanwhile, and the patient was entirely left to his own resources.

On my return I found that he had coped with his difficulties extremely well. He left the Clinic and was a district doctor, had his own flat and had passed through the siege of Budapest unscathed. He was living with his girl-friend, though not married. He seemed settled, the speech defect had almost entirely vanished. My flat had been bombed out and so I was obliged to go back to the country for a while. Continuation of the analysis was left open as he had not decided if he wanted to go on. I returned to the country and came back definitely to Budapest in the summer of 1945.

Meanwhile, external circumstances had intervened deeply in his analysis and his relationship to me. While away in the country my mother, who was living alone in her flat in the same district of which he was the doctor, contracted typhoid fever. He was called and found out that it was my mother. He treated her and transferred her to a hospital, where she died.

I returned 2 months later, learnt what had happened and we talked things over. He had married his friend in the meanwhile and had made up his mind that he would not continue analysis. He said that he was feeling well and hoped to get on all right. The interlude of the death of my mother was mentioned only on the reality level and I decided to leave it at that momentarily.

I heard from him sometimes. He seemed all right, working, and quite well adjusted. He had changed profession again, had studied X-ray work and had taken an excellent degree. His wife was pregnant and they seemed well settled.

THE SECOND PERIOD OF ANALYTIC CONTACT

At the time I considered the episode of my mother's death and my sojourn in the country during the siege as rather unfortunate for the patient, in spite of his seemingly excellent adaptation to circumstances. Still, nothing could be done about it, since at the time most inhabitants of Hungary were subjected to the most trying events.

Two years later the patient asked for an interview. He told me that he had a son aged 2 years, that his marriage was more or less satisfactory and that he was having serious problems since he had been involved in anti-semitism, and now he had a Jewish wife and a son who was half Jewish. He was very unhappy, feeling insecure and at loss how to judge himself, his principles and his emotions. He did not know what to think of himself and he was unable to understand how he could have married just as he had and still feel as he was feeling. He was frightened again, and at the same time very much afraid that he would hurt his wife if he said anything about his problems. Still, he had no idea, and no security about what he would do next since he was experiencing at the same time contradictory emotions. Suddenly he asked me what I was thinking—was it possible, that he was psychotic?

I tried to evade the question, but at last was forced to say that I did not know, but if he was it was better to face the fact and try to handle it as such so as to be able to live tolerably. This answer seemed to satisfy him, and he asked me to continue his analysis since he was afraid to face things without aid. Once on the couch he told me that it was my

sincerity that had saved the situation, for if I had tried to lie about it, he would never have believed anything I said. He knew, by now, that he was psychotic, he had diagnosed himself as being schizophrenic.

Once more the analysis started on the transference material, this time intermingled with reality.

He had continued to 'work upon himself' while I was away. He had realized that I represented his mother but was not identical with her. At present his relationship with me represented the only reality—control—faulty and 'wretched as it was, because of my shortcomings' there was no better one, and he resolved to make the best of what he had. Moreover, the fact that I too had my own troubles (alluding to my mother's death) made some of my shortcomings pardonable. On the whole he had some confidence in me, and he was by now fully aware of the fact that he was suffering from a psychosis. He had accepted it and resolved to try and live with it, using his analysis as a sort of emergency device to keep him going and help him to balance himself. During my absence he had consulted a psychiatrist who, hard pressed by the patient, had confirmed his own diagnosis.

Actual difficulties were discussed. His wife had Communist sympathies and, partly under her influence and partly because of fear of the consequences of his former political career, he reluctantly joined the Communist party, on the basis 'I never can do what I want because I never want anything whole heartedly, but want two opposites that exclude each other at the same time'. His party career proved very short and unsuccessful. His marriage was on the whole good but he began to notice an ever-widening gap. His demands for love—everything for nothing—began to wear out his wife who, after having honestly tried to satisfy all his emotional needs, began to distance herself. She had another child, a little girl, a very difficult delivery, after which she was ill for a long time, and was unable to centre all her

interest upon her husband. Paranoid projections, this time directed mostly against his wife, of having a lover, etc., promptly arose. In analysis, every new projection again appeared in the transference—I should say, was tried out in it. After having voiced these accusations, he was able to separate them from reality and recognize them as fantasies.

The chief subject of this period was his relationship to others, always experimentally tried out in analysis. Some of these projective fantasies were really psychotic, for example I had been informing the police about his analytic problems. After these and similar projections were allowed to develop and formulate he was able to realize that they were fantasies. Their intensity slowly decreased. He began to accept his ambivalence and said 'that he had to live with this constant internal insecurity as a lame man had to tolerate his crippled foot'. He got to be extremely fond of his second child, a very beautiful little girl. He had also changed externally; he put on weight and instead of purely asthenic build, athletic constitutional features developed.

In his everyday life he seemed successful. He was very good at his job, quarrelled less and learned how to handle himself. If he had a bout of 'diffuseness' he would avoid doing anything decisive and wait for its end. He had learned to control his temper and bursts of aggressiveness, and instead developed an excellent quality of tolerance which he applied in his work. On the whole he seemed to be able to get on quite well.

In 1949 we decided that he was able to go on alone. On the whole he was feeling well; he had learned to live with his shortcomings without losing his internal balance if some of his symptoms reappeared in a much milder form. I promised to take him back any time he seriously needed it.

His stammering had entirely vanished by this time.

At this stage he seemed reasonably well. Emotionally, he had formed some attachments. He was fond of his daughter, also of

his son, though with the latter he was more or less ambivalent. He had an ambivalent attachment to his wife, not bad on the whole, though he maintained that he did not care for her much sexually—he did not consider her pretty enough. Still he 'had grown accustomed to her'. He had an emergency attachment to me. He liked his work, and aggressiveness depression and 'diffuse' states had almost entirely disappeared.

EXTRACTS FROM THE THIRD PERIOD OF TREATMENT

In 1954 I had an urgent telephone call from my former patient, asking for an interview. Since one of the rules that I had always observed was to comply with his wishes if possible, especially so since he had learned—and I, too—that he only asked for help when in serious need, I saw him on the same day. He came complaining of an intense, agonizing fear without real cause. He could not sleep, work or focus his attention upon anything but spent his time constantly watching his ever-increasing fear. This state had developed gradually. At first he would wake from sleep with a start, feeling afraid. He was unable to find out what he feared. These states became more frequent, and panic would suddenly flood over him while working, or riding in a bus, or speaking with people. Perspiration covered him, and he became paralysed with fear. He became unable to work and believed that this time he was really going insane.

I agreed to undertake treatment. The first few sessions were filled with descriptions of his terror. Fleeting bodily sensations appeared but promptly disappeared, before becoming clearly defined. The essence of his fear seemed to be the fear of being alone.

The sessions comforted him somewhat and he was very reluctant to leave. Then he began to relate his actual conflict. His marriage had been slowly deteriorating. His wife had lost her patience with him and had become entirely wrapped up in her children, and he suspected her of having fallen in love with someone and having an affair. This time his supposition did not seem as unreal as formerly. He had drifted into a love affair with a very pretty, much younger woman, with whom he was closely associated in the course of his everyday work. She had fallen in love with him very seriously. This affair had been going on quite smoothly for 2 years. Shortly before his series of panic attacks he had discovered that his lover had been flirting, and very probably also carrying on an affair with another married doctor. He had discovered this quite accidentally—by overhearing a conversation. At the same time his wife had discovered that he was having an affair with this girl. She caused a scandal and suddenly he found himself ousted from his double emotional security. Instead of two loving women he now had none. Both had been transfigured into what he called 'harpies'—out for his blood.

Gradually the structure of the emotional conflict-situation became defined. In his habitual splitting attitude he had made for himself two parallel lives: a home, family, wife and children, and a lover, chiefly, as he put it, 'for the satisfaction of his sexual and emotional needs'. His wife had been having a gynaecological operation after her second pregnancy. She had grown old and was no longer pretty and no longer a satisfactory partner. He did not intend to leave his family as he was fond of his children and wanted to provide them with a satisfactory home and upbringing. He felt no responsibility towards either woman.

Then childhood memories re-appeared. Again there was hate and anger towards his mother who had grown very much more attached to his younger brother, of whom he was incredibly jealous and hated cruelly. Gradually the entire picture became dominated by his emotional ambivalence towards his mother. I discovered that one of the components of the acute conflict was the death of his mother, which he had omitted to mention during the first eight sessions

though it had happened 2 weeks before the onset of the panic attacks. His mother had a stroke and died suddenly. During the last few years of her life their relationship had been very superficial. His father had been left alone and he was obliged to care for him, which was very much resented by his wife who disliked his family. This was an additional conflict as he had also quarrelled with his brother and even with his sister so that the fear of 'being left alone' proved quite real, but in the reverse—he had left everybody.

The entire childhood conflict material came once more to the surface. During this phase of the analysis his stammering which had almost entirely vanished, appeared again. Altogether this phase of the analysis differed in many respects from the former phases. There were no paranoid projections. Ambivalence and negative emotions—hate, anger, aggression—were openly recognized and rather high degrees of tension tolerated. The anxiety state, which had caused him to seek help, gradually disappeared. Actual problems were being faced with much more reality sense than ever before.

The conflict material mobilized parallel memories of the mother–child relationship. Behind this screen of dependence and love guilt feelings for his aggression appeared. He clearly recognized that behind his feelings of persecution there always lurked a sense of guilt, usually for having shirked some responsibility. At last he realized that he really desired to live a life without any responsibility, his greatest desire was to cease to exist as a separate personality. His demands towards his wife, lover, or analyst had all the same tendency. Conscious realization of this desire caused no change in its intensity.

At this period he had some peculiar dreams. The first of a series appeared, when he realized, that he did not care to act as a full-grown man in his love life either. The dreams were as follows: he was sitting naked in his room. Looking down upon himself, he noticed that he had an immense penis in erection, as long as his arm. He thought it

would be in his way and unscrewed it as it was merely screwed on. He took it off, opened an empty drawer in his writing-table, put it in and then locked the drawer and placed the key in his pocket thinking, in his dream, that he could take it from the drawer any time he would want it. On looking at himself again he discovered that he had grown a small penis and he thought it would suffice his needs. His associations were: he did not want any women, his penis as himself was too good for them, and his big penis was bigger than any living man possessed, it was omnipotent.

His second dream came about a week later. He had been struggling with the problem of how good it would be to be self-sufficient, and need no sex partner. Women were disgusting. Childbirth, menstruation, all the physical consequences of female sex life were occupying him at the time—his girl friend had been pregnant and had a spontaneous abortion. He dreamt that he was bleeding from his anus. The blood turned quite black on leaving his body and changed into faeces, this broke into little pieces and these pieces changed into many small crocodiles which rapidly changed into grown-up ones. His interpretation of the dream was that it was a birth fantasy, but he was only pregnant with hate and aggression and the faeces-crocodiles were the aggression he had been carrying in his bowels all his life. Now that he had let them out they were becoming dangerous, ready to devour everybody, even him. He believed that this was the real cause of his anxiety.

After this dream his condition changed. He patched up his quarrel with his friend, settled his quarrel with his wife and in analysis became friendly. The speech defect, which had been occasional, entirely disappeared. Then he gradually settled down. He had reached a *modus vivendi* with both women, his wife ceased to quarrel, he forgave his girl-friend, anxiety had disappeared and his marriage continued on the sham *pater familias* level.

Consequently, we both decided to stop analysis for the time being.

THE FOURTH PERIOD OF THERAPY

After 2 years pause he again asked to continue. This time he had had a serious shock: his girl-friend had attempted suicide.

He had been going on as before. A great deal of his time and interest was taken up by the organization of his work. He was interested in, and caring for, his children, especially his daughter. On one occasion he said 'the only woman that I will be able to love is M. my daughter'. His girl-friend had been making scenes from time to time, telling him that she was lonely and that she wanted a child. He was terrified by the prospect, since he was trying to keep the situation unchanged.

After a Christmas holiday which she had been forced to spend alone—he had been away with his family—she invited him to her flat, cooked supper, served drinks, and while in the kitchen swallowed quantities of luminal. She became very sick, comatose, and he had to call an ambulance and take her to the hospital. He was shocked and furious. It was at this stage that he asked for analysis once more, saying that he was unable to live with this burden and his whole life had again been reduced to an emotional chaos.

Once more he became 'diffuse', to the extent of being forced to take a holiday since he considered himself unreliable in his work. All his pent-up aggressive feelings broke forth. He was furious of having been forced to look on while his friend had attempted suicide and was suffering from the consequences—she almost died. Then some paranoid projection appeared: he accused her of having created a situation in which he could have been accused of murdering her, she would have ruined his life, his career and left him at the same time with a terribly bad conscience. She got better, but he did not go to see her at the hospital. His wife did not hear about the suicide attempt. Having recovered, his friend left for the country. After some time she returned and they started working together. He did not wish to speak to her any more, he inter-

preted the suicide attempt as a pure act of aggression directed against him. He told all this to the girl, who immediately asked to be transferred to another hospital. At this he broke down, cried, and discovered that he loved her, could not live without her so they were again reconciled. At this junction, for the first time in all his analysis, he discovered that he was carrying some responsibility.

Dreaming stopped. The speech disorder disappeared. His life was going on very much as it had been before. He is gradually withdrawing from his wife, who seems to have lost emotional interest in him. He still cares for his children, especially for his daughter. He is suddenly ageing. Again hypochondriatic complaints have appeared: fear of tuberculosis, anaemia (without any real basis). He has made up his mind, at least theoretically, that if his children will grow up, he will marry his friend, if she is willing to wait for him till then. Until then the double life continues—he seems quite comfortably settled in it. The same is valid for analysis. I am again an emergency mother substitute. He has acquired some confidence in me: at every session he takes off his boots, asks for a rug, rolls himself in it, and feels very snug. He does not want to leave at the end of the session. He told me that though this was no analysis at all, and as an analyst I am not worth a penny, he still likes to come, because this is the only place in the world where he dares to be himself, as he is. Every now and then he will remind me that I left him alone during the war, and I am just as unreliable as his mother or any other woman.

Homosexual problems have been gradually brought into analysis. He gradually discovered that he wanted to have all the emotional advantages of women and did not wish to be a man. Men interested him, but physically not quite enough. So he considered his own manner of living quite excellent.

He believes that he is growing old (he is 50) and he wishes to settle down. He came to analysis 'because it is good to talk to you, and it is cheaper than if I asked you out to

dinner'. It did not even occur to him that I might not accept the invitation.

At present he is considering whether he should stop or not.

Judging from the antecedants of the case, I believe he will, sooner or later, and after a period of relative well-being get involved again in some kind of emotional problem, and seek help once more.

DISCUSSION

This case raises many problems which I shall try to deal with one by one. First the presenting symptom, which was in this case stammering, amounting almost to an inability to speak.

Before accepting the patient for analysis, I had been engaged for many years in research with stammerers. I had investigated many stammerers with regard to both their motor symptoms and speech function as well as their psychological problems. The result of these investigations led to unexpected results. They were published in 1939 in the English periodical *Speech*. Here I intend only to sum up the most important findings since they seem relevant to the case I have been describing in this paper.

In all the stammerers I had seen the co-ordination and integrative function of the two hemispheres seemed more or less incomplete. It even occurred to me that if stammering develops on a hereditary basis it may be rooted in an inborn asymmetry of the two halves of the body. I carried out a series of experiments which seemed to point to this conclusion. The speech function itself has many pathological features. I tried to find out what were the accompanying innervations of Flatau's well-known symptom and came to a rather startling conclusion. At the moment when Flatau's symptom occurs, the stammerer simultaneously innervates all his neck-muscles, his masseter muscles, and also his diaphragm and abdominal muscles. The latter are normally antagonists. If simultaneously innervated they produce intense

pressure upon the bowels and inhibit breathing. This schema of innervation is spontaneously practised only either during defecation or when a person is suddenly frightened and *gasps*. In both cases breathing is inhibited. The connexion of aggression and defecation is well established and that of gasping and fright also.

If one tries to analyse the expressive contents of this innervation, eventually transposing it into a four-legged position, it becomes exactly the innervation used by any animal when crouching before attack. It is an innervation preparatory to an aggression and yet also expressing fear. This innervation prevents breathing, which is the basis of speech, and also causes a rise of muscular tone in all muscles of the ventral surface of the body, the surface left unprotected by the upright posture adopted by man.

The innervation of the masseter muscles inhibits the fine movements of the mandibular articulation, thereby preventing precise articulation. In normal development, in the course of speech learning, the function of *biting* and *speaking* become separated. The functional analysis of the motoric pattern of stammering speech proves, that in these cases this separation is only very superficial, and when the threshold of emotional intensity rises the function is apt to regress.

In the case of my patient all these symptoms were present in an intense form and disappeared only very gradually. The aim of speech therapy was to help to clear the functional basis of speech.

My patient was originally left handed. The high occurrence of left handedness among stammerers, enuretics and epileptics is well known. We have been studying the development of handedness, that is hemisphere dominance, at the Child Guidance Centre where I work. We were able to establish that left handedness is hereditary and hemisphere dominance an integral part of the body-ego. The essence of hemisphere dominance is that the dominant hemisphere works with greater speed and exactitude, a faculty which is not

fundamentally changed by any mode of training. The difference seems inborn. If an originally left-handed child is trained to change hemisphere dominance, he is forced to live with worse faculties than he is capable of. Since the development of the ego is closely linked with the conscious use of the dominant hand, and the primitive form of the ego is a body-ego, the left-handed child, who is not allowed to use it, is forced to split his ego entirely in a very disadvantageous manner. This has far-reaching psychological consequences. What is basically good for him is not good for the environment; he has a good hand and a good brain but he is not allowed to use it. He is forced to develop an aspect of his personality with *which he is never able to fully identify*. A fundamental splitting of the ego is produced.

In the patient described in this paper, this splitting and its consequences, even its appearance in his symptoms, is very clearly defined. He is never at one with himself. His personality is always oscillating between such extremes as naturally would exclude each other. His ambivalence is so great that he is almost unable to establish even a passing unity of emotion. In his 'body sensations' it is *the left hand*, which is really his, that starts to grow bigger. The final feeling of omnipotence starts from his *left* side. In the observations carried out during the research work into the development of hemisphere dominance, we always found that the patients when touching their own body, nail biting, scratching, even masturbation, always used the originally dominant hand.

The patient had been very rigidly trained to use his right hand; consequently he was never skilful, which was a severe handicap in his profession.

In the analysis this patient exhibited various psychotic features. I concluded that he was psychotic but was nevertheless able to organize his life, partly with the help of analysis, so that he could live, work and avoid the necessity of even transitory institutionalization.

The psychotic features of the personality were as follows:

An extreme degree of ambivalence, really a split personality. His emotions and drives were habitually opposed. Even after many years of analysis, the normal integration of personality structure only occurred to a very limited degree.

During the analysis psychotic phenomena occurred including 'diffuse' states, serious regression and paranoid projection.

The emotional and sex life of the patient have not been satisfactorily solved. Perhaps no such solution is possible.

His object-relationships were not integrated.

This case presents features that seem to justify Melanie Klein's formulation concerning the *schizoid position*. His case is like that of a person hovering on the verge of the schizoid and depressive position unable to outgrow either. His dream of the faeces turning into live crocodiles and his associations to the dream are consistent with these theories.

This 'split-up' personality structure, which in turn points to a deeply rooted fixation in the schizoid position, appears to exert a lasting influence upon the personality pattern of the patient. In fact, it seems that the Kleinian theory is the only one that offers a satisfactory basis for the evaluation of the case.

Lastly, I should like to formulate some facts on basis of the research work carried out on stammerers as a working hypothesis.

The schizoid position, the technical term established by Melanie Klein, seems to hold true in a certain phase of life when the function of the nervous system as a whole is not yet integrated. The successful integration of the personality is inseparable from the normal development of the body-ego based upon the functional integration of the nervous system, especially *the normal assimilation and integration of sensory stimuli*. An important step in this integrative process is the normal development and use of the master hand.

Stammering is a functional disease with very many schizoid features. This patient is only an extreme example of this case. The high incidence of left handedness among stammerers and their disadvantageous situation in a dominantly right-handed society is only one aspect of the problem.

If environmental traumata are superposed upon a not quite normal foundation, as in the case of the patient described, the splitting of the personality can become definitely established. Development is arrested at a certain developmental level and an abnormal personality structure may develop as has been the case with this patient. This case is a border-line schizophrenic case with a comparatively fortunate outcome.

Another decidedly psychotic feature of the patient is the *discontinuity of psychic material*. A certain problem would arise, dominate the entire scene for a while, and then suddenly disappear without leaving any trace or consequence. In some instances the same problem would arise once more, eventually after some years, but very often remain quite disconnected with the original manifestation of the same solutions. In fact, his central problem, which prevents the solution of his emotional problems originates from the same features: emotions and emotional states remain and *exist in a disconnected state*. Therefore his emotional life consists of a series of separate disconnected emotional blocks.

SUMMARY

A case is described of a border-line psychotic stammerer and the different phases of an exceedingly long analysis. The case material permitted some theoretical conclusions, justifying Melanie Klein's theory concerning the schizoid developmental position.

The suggestion has been made in the paper that hemisphere dominance is an important step in the establishment of a healthy body-ego and that the latter is the foundation of a normal personality structure. Stammering is regarded, on the basis of other research material, as a deep regressive disorder *originating from a fixation in the schizoid developmental position*, manifesting itself chiefly in the disconnectedness of emotional reaction and presenting a certain element of periodicity and projection.

The sedation threshold of psychoneurotic and alcoholic patients

By J. MOFFAT and S. LEVINE*

One of the main problems besetting clinical psychiatry today is lack of scientific objectivity. In recent years much research has been aimed at producing tests useful as diagnostic aids to clinicians. All too often, as in the case of the Funkenstein test (Funkenstem, Greenblatt & Solomon, 1952), they have proved of doubtful value, or have been beyond the scope of the practising psychiatrist. Recently, however, a test has been developed from the original studies of the sedation threshold, (Shagass, 1954, 1956*a,b*, 1958; Shagass & Naiman, 1955), which is claimed not to have these disadvantages and to be of diagnostic assistance. Shagass & Jones (1958) studied a large series of psychiatric patients by this method and were able to separate anxiety states from hysterical personalities, and neurotics from psychotics. The original technique has since been criticised from the point of view of assessing the end point by E.E.G. changes (Ackner & Pampiglione, 1958; Boudreau, 1958; Seager, 1960), and by the occurrence of slurred speech (Thorpe & Baker, 1957; Ackner & Pampiglione, 1959). Shagass attempted to simplify his technique by using a sleep threshold and so dispensing with E.E.G. findings, but he found this unsatisfactory (Shagass & Kerenyi, 1958).

Claridge & Herrington (1960) eventually developed a modified sedation threshold technique which appears simple to perform. They used this originally as a research tool, but stated recently: 'Continuous experience with this technique over, at the time of writing, a period of more than a year, has shown it to be even more satisfactory than was hoped. Requiring little apparatus the method may be

easily duplicated by other workers, and in addition to its use as a research tool, for which purpose it was originally designed, it has proved helpful to the clinician as an aid to diagnosis' (Claridge & Herrington, 1963). This last statement seemed worthy of further attention and stimulated the present investigation.

The test was applied to a group of psychoneurotic patients and to a group of non-psychotic alcoholic patients. It was felt that the latter represented a group in which such a test might be of assistance. Alcoholics, irrespective of the underlying diagnosis, tend to present at hospital with similar clinical pictures, the principal feature being the considerable social and physical deterioration which they demonstrate. It was decided to see whether the sedation threshold could be used to identify those patients who would subsequently be shown clinically to be suffering from a dysthymic state in the Eysenckian sense, i.e. an anxiety state or neurotic depression, and who would therefore be suitable for appropriate treatment.

MATERIAL AND METHOD
Choice of patients

Twenty-five adults suffering from a variety of psychoneurotic states and twenty-five non-psychotic alcoholic patients were selected for the test. All were undergoing in-patient treatment and were well known to the investigators, who placed them in psychiatric diagnostic categories on clinical evidence. The alcoholic group were placed in these categories after the acute stage of their alcoholism had been treated, and the full history and clinical picture thoroughly known and evaluated. None of the patients investigated

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were mentally defective, had signs of brain damage, or a history of drug habituation.

The definitions of hysterical personality, neurotic depression and anxiety state are similar to those used by Shagass and his colleagues in their various papers. The fourth (alcoholism) is taken from the W.H.O. definition of alcoholism (Jellinick, 1951), and the fifth (psychopathic personalities) is based on Henderson's definition of psychopathy (Henderson, 1939). These clinical diagnoses were then translated into the Eysenckian Classification of dysthymia and hysteria/psychopathy (Eysenck, 1957).

Method. All fifty patients had agreed to the request to carry out the test. The alcoholic patients had all been successfully withdrawn from alcohol. In all cases medication was stopped for a minimum period of 48 hr. before testing.

The sedation threshold test was performed according to the directions of Claridge & Herrington (1960, 1963) and consists of the effect of sodium amylobarbitone on a simple task of attention. The stimulus material consists of random digits from one to nine relayed at 2 sec. intervals through earphones. The patient responds to the stimulus by attempting to double the digits while receiving a continuous intravenous infusion of sodium amylobarbitone at the rate of 0.1 g./min. The digits are grouped on a score sheet in blocks of five, and a record is kept of the errors made in each block. The threshold is taken 'as the point mid-way between the last two blocks with less than 50 % error, and the first two blocks in which errors exceeded 50 %' (Claridge & Herrington, 1963). The amount of drug administered at this point is determined and is the sedation threshold when expressed in mg./kg.

In this investigation the Maudsley Personality Inventory Neuroticism Scale (M.P.I. *N*-scale) and the Taylor Manifest Anxiety Scale (M.A.S.) were also administered, and the mean scores for neuroticism and manifest anxiety obtained for each group.

RESULTS

(1) *Mean sedation threshold (mg./kg.) for each group*

Table 1

	Alcoholic dysthymics ($n = 9$)	Alcoholic hysterics/ psychopaths ($n = 16$)	Psycho-neurotic dysthymics ($n = 12$)	Psycho-neurotic hysterics/ psychopaths ($n = 13$)
Mean	10·24	8·53	9·39	8·17
S.D.	5·55	1·97	2·35	2·99

t-tests: alcoholic dysthymics *v.* alcoholic hysterics/psychopaths, $t = 1.13$ N.S.; psychoneurotic dysthymics *v.* psychoneurotic hysterics/psychopaths, $t = 1.13$ N.S.

It is interesting to note that the actual sedation threshold results are similar to those obtained by Claridge & Herrington, but no statistically significant differences can be demonstrated when the dysthymic and hysteric/psychopathic groups are compared.

(2) *Mean M.A.S. scores for each group*

Table 2

	Alcoholic dysthymics ($n = 7$)	Alcoholic hysterics/ psychopaths ($n = 15$)	Psycho-neurotic dysthymics ($n = 12$)	Psycho-neurotic hysterics/ psychopaths ($n = 13$)
Mean	29·43	26·67	29·42	34·08
S.D.	4·35	9·35	11·39	5·45

t-tests: alcoholic dysthymics *v.* alcoholic hysterics/psychopaths, $t = 0.74$ N.S.; psychoneurotic dysthymics *v.* psychoneurotic hysterics/psychopaths, $t = 1.32$ N.S.

The scores obtained in this test are considerably higher than those of Claridge & Herrington, but again no significant differences can be demonstrated when the dysthymic and hysteric/psychopathic groups are compared.

(3) *Mean N-scale scores*

Table 3

	Alcoholic dysthymics (n = 7)	Alcoholic hysterics/ psychopaths (n = 15)	Psychoneurotic dysthymics (n = 12)	Psychoneurotic hysterics/ psychopaths (n = 13)
Mean	32·86	30·27	29·08	37·92
S.D.	10·51	10·39	9·55	5·60

t-tests: alcoholic dysthymics *v.* alcoholic hysterics/psychopaths, $t = 0.5$ N.S.: psychoneurotic dysthymics *v.* psychoneurotic hysterics/psychopaths, $t = 2.55$, $P < 0.01$.

The results obtained are comparable to those for dysthymics and hysterics in the Claridge & Herrington series. The psychoneurotic hysteric/psychopathic group show a significantly higher degree of neuroticism than the psychoneurotic dysthymic group.

(4) *Correlation co-efficient*

The correlation coefficient between sedation threshold, M.A.S. and *N*-scale were calculated for the total group and various subgroups. The results can be summarized as follows: correlation may exist between any two of the three variables—(1) sedation threshold; (2) M.A.S.; and (3) *N*-scale. Correlation coefficients will be denoted by '*r*', i.e. $r\,12$ is the correlation co-efficient between sedation threshold and M.A.S., etc.

Table 4

	$r\,12$	$r\,13$	$r\,23$
Whole group	+0·08	−0·01	+0·86*
Psychoneurotic dysthymics	+0·18	−0·03	+0·93**
Psychoneurotic hysterics/psychopaths	0·00	−0·04	+0·45
Alcoholic dysthymics	+0·28	+0·18	+0·92**
Alcoholic hysterics/ psychopaths	+0·15	+0·11	+0·93**

* $P < 0.005$;   ** $P < 0.01$.

The main point to be noted from Table 4 is the lack of correlation between sedation threshold and any other measure. The close correlation between M.A.S. and *N*-scale in all but one subgroup is the only positive finding. This has been noted by other workers (Spence & Spence, 1964).

DISCUSSION

The results show that the sedation threshold test failed to differentiate the dysthymics from the hysterics and psychopaths either in the psychoneurotic or the alcoholic group of patients. Nor did the sedation threshold results correlate significantly with the M.A.S. or the *N*-scale of the M.P.I.

When Claridge & Herrington (1960) published their first report they found that sedation threshold separated the dysthymic and hysteric groups. They also considered that it correlated significantly with M.P.I. neuroticism scale and the M.A.S. results, thus suggesting a relationship between sedation threshold and the personality factors of manifest anxiety and general neuroticism. Their second study (1963) again demonstrated that sedation threshold could separate dysthymia from hysteria but failed to confirm the correlation between sedation threshold results and M.A.S. and *N*-scale results. The failure in this study to confirm the findings of Claridge & Herrington (1960, 1963) and Shagass & Jones (1958) may reflect differences in selection of case material. Although some of the hysterics had conversion symptoms they were certainly not directly comparable with the bland conversion hysteria used by Claridge & Herrington. The group of hysterics in the present study are certainly capable of showing considerable anxiety and the marked discrepancy between the M.A.S. scores in the two studies demonstrates this. It was felt, however, that the diagnosis of hysteria could not be confined to the relatively rare bland 'la belle indifference' group. The more common hysterical personality presents more of a problem both clinically and numerically and if the test is to be useful it

should be able to separate them out as indeed Shagass & Jones (1958) felt that it could. The manifest anxiety shown by the hysterics/psychopaths in this study might also account for the unexpectedly high mean M.A.S. score of the psychoneurotic hysteric/psychopathic group (Table 2). The same group also had a significantly higher mean N-scale score than the psychoneurotic dysthymic group (Table 3). The close correlation demonstrated between the M.A.S. and N-scale results (Table 4) suggests that these two tests were measuring the same qualities and this could account for this latter finding.

So far as the actual technique of the test is concerned, this was found to be quite satisfactory. Martin & Davies (1962) had previously attempted to use this technique in order to separate depressive states, but found difficulty in obtaining satisfactory end points. It is possible that their difficulty lay in the presence of depressive symptomatology with resultant retardation, failure of concentration, and loss of interest. Little difficulty was experienced in this study in obtaining satisfactory end points as described by Claridge & Herrington.

Besides the apparent inability of the test to differentiate between possible qualitative differences in anxiety and variations in the extraversion—introversion personality dimension there was an interesting variability in individual response which, it was felt, might well have affected the results. It seems likely that the sedation threshold as with other physiological tests, is affected by many factors other than the clinical condition under investigation. Silverman, When & Slimavonicin (1963) have studied the individual and environmental influences which might govern test results, and concluded that there were many such factors '... including the hereditary background and learned experiences which predispose to certain response tendencies, the immediate pre-existing psychophysiological state, and the nature of the stimulus and its

meaning to the organism'. Several patients, both dysthymics and hysterics displayed an increase in manifest anxiety at the time of testing which could have had an effect on the result. This occurred particularly in relation to the use of venipuncture, e.g. one woman with a previous unhappy experience of venipuncture became quite distressed at the prospect of the injection. This simple manoeuvre has been the subject of previous study by Coppen & Mezey (1960) who found it to have quite profound metabolic effects, causing an 11 % rise in the basal metabolic rate. It would appear through observations of the behaviour of many of the patients in the test situation that such factors could well have influenced the results.

SUMMARY

An investigation was devised to test a claim that a modified sedation threshold technique was helpful to the clinician. Twenty-five diagnosed psychoneurotic patients and twenty-five non-psychotic alcoholics were tested in order to find whether the dysthymic group, that is anxiety states, obsessional states, and neurotic depressions, could be separated from the hysteric/psychopathic group. It was found that this method, though simple to perform, failed to demonstrate any significant differences between these groups. No significant correlation was found between the sedation threshold and the Taylor Manifest Anxiety Scale or the Maudsley Personality Inventory N-scale. A close correlation was found between the M.A.S. and N-scale.

Some suggestions were made regarding reasons for the failure to confirm previous findings.

REFERENCES

ACKNER, B. & PAMPIGLIONE, G. (1958). Discussion on physiological measurements of 'emotional tension'. *Proc. Reg. Soc. Med.* **51**, 76–81.

BOUDREAU, D. (1958). Evaluation of the sedation and threshold test. *Arch. Neurol. Psychiat.* **80**, 771–5.

CLARIDGE, G. S. & HERRINGTON, R. M. (1960). Sedation threshold, personality and the theory of neurosis. *J. Ment. Sci.* **106**, 1568–83.

CLARIDGE, G. S. & HERRINGTON, R. N. (1963). Excitation–inhibition and the theory of neurosis: A study of the sedation threshold. *Experiments with Drugs.* Ed. H. J. Eysenck. Oxford: Pergamon Press.

COPPEN, A. J. & MEGEY, A. & G. (1960). Metabolic effects of vein puncture on man. *J. Psychosom. Res.* **5**, 56.

EYSENCK, H. J. (1957). *The Dynamics of Anxiety and Hysteria.* London: Routledge and Kegan Paul.

FUNKENSTEIN, D. H., GREENBLATT, M. & SOLOMON, H. (1952). An autonomic nervous system test of prognostic significance in relation to electro shock treatment. *Psychosom. Med.* **14**, 347–62.

HENDERSON, D. (1939). *Psychopathic States.* New York: Norton.

JELLINECK, E. M. (1951). W.H.O. Expert Committee on Mental Health. Sub-Committee on Alcoholism. *Tech. Rep. Wld Hlth Org.* no. 42, p. 20.

MARTIN, I. & DAVIES, B. M. (1962). Sleep thresholds in depression. *J. Ment. Sci.* **108**, 466–473.

SEAGER, C. P. (1960). Problems in technique concerning the sedation threshold. *Electroenceph. Clin. Neurophysiol.* **12**, 910.

SHAGASS, C. (1954). The sedation threshold: a method for estimating tension in psychiatric patients. *Electroenceph. Clin. Neurophysiol.* **6**, 221–33.

SHAGASS, C. (1956*a*). The sedation threshold as an objective index of manifest anxiety in psychoneurosis. *J. Psychosom. Res.* **1**, 49–57.

SHAGASS, C. (1956*b*). The sedation threshold. A neurophysiological tool for psychosomatic research. *Psychosom. Med.* **18**, 410–19.

SHAGASS, C. (1958). Neurophysiological studies of anxiety and depression. *A.P.A. Psychiat. Res. Rep.*, no. 8.

SHAGASS, C. & JONES, A. L. (1958). A neurophysiological test for psychiatric diagnosis: Results with 750 pts. *Amer. J. Psychiat.* **114**, 1002–9.

SHAGASS, C. & KERENYI, A. (1958). The 'sleep' threshold. A simple form of the sedation threshold for clinical use. *Canad. Psych. Ass. J.* **3**, 101–9.

SHAGASS, C. & NAIMAN, J. (1955). The sedation threshold, manifest anxiety and some aspects of ego function. *Arch. Neurol. Psychiat.* **74**, 397–406.

SILVERMAN, A. J., WHEN, S. I. & SLIMAVONICIN, B. M. (1963). Perceptual and environmental influences on psychophysiological responses. *Recent Advances in Biological Psychiatry.* Ed. J. Wortis. New York.

SPENCE, K. W. & SPENCE, J. T. (1964). *J. Abnorm. (Soc.) Psychol.* **68**, 2, 144–49.

THORPE, J. G. & BAKER, J. C. (1957). Objectivity of the sedation threshold. *Arch. Neurol. Psychiat.* **78**, 194–6.

The second childhood: observations on treatment

By LOUISE F. W. EICKHOFF*

For making the doctor think clinically there is nothing better than stripping him of his scaffolding of instruments, drugs, and 'auxiliary personnel' and placing him in a situation of imperative medical need outside his own speciality. It is a shock therapy which divests him of his medical habits, out of which, from constant practice, much of the meaning of medicine may have drained. This can be beneficial to the clinician himself but furthermore, although his unique handling of the situation may be incorrect or inadequate, his mistakes and the questions he asks himself in this new approach may throw light on another speciality in danger of becoming systematized and mechanical from habitual practice.

In this manner I, a children's psychiatrist, was forced to regard a geriatric problem. A woman of 81 years had all her days been regarded as the fool of the family although she had been as highly intelligent as the rest of her siblings; but she had been a weakling requiring much care until she was 7 and the sheltering and direction were continued after this, past the probable need. The legend grew up that it was useless expecting her to do something because she was not capable on her own; there was always someone in the house who could do it better.

She was one of the three sisters who remained spinsters and their home in their retirement was that of their niece, a capable woman in a dominant position, an intellectual with such an abhorrence of sentimentality that emotional expression had been sublimated into the Arts or dissociated into symbols: it was never personal or physical. Two of the sisters, although acknowledging her as the

mistress of the house, yet remained mistresses of themselves. It was easy, when there were three of their kind, and even when there were two, to balance and withstand this dominant niece who could even decide for others what they did or did not like.

But the two older sisters died leaving the patient a single weak force under the direction of the potent niece. The latter had many of the qualities of a father figure. She was authoritarian and dogmatic; her decision was final in the house and at her work. To the weak she appeared almighty. She was ever able; she had a toughness of physique that made her unbeatable by circumstance, and indefatigable; she went on regularly and perpetually, almost immortally, like the good husband of the infant's mother. Moreover, as she was out of the house from 7.30 a.m. until after 7.0 p.m. daily, and retired to bed between 9.30 and 10.0 p.m., during the greater part of the day she remained for her home an invisible force. No one went to her for the gentler comforts but many went as to a father for support, guidance in worldly matters, and for the awakening and furthering of intellectual interests. Indeed her own high intelligence and wide interests made her judgement wise and accurate on many matters so that for the patient, with her waning intellectual powers, her niece must have seemed to have the infallibility of God.

Here then for the ageing patient was a toddler relationship with the Super Ego. Although this is an extreme example, emphasized by the quality of the personalities concerned, I think it is by no means unusual. Where the impotent is protected by the active and able there will be a toddler: Super Ego feeling about the situation. My old lady grew less able to move about; her hobby, the

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theatre, had to be relinquished and her religious activities curtailed. She was left with little or no expressive outlet for her affection and emotion, and Mrs Dale's fantasy diary gave her a family which, being more alive than her own was to her, succeeded in stimulating her affections and emotions without satisfying her needs and desires. Each day added to her store of unsatisfied emotion which perforce she had to keep to herself for she was alone all day except for the matinal servant, who made no personal relationship. The homecoming of the Super Ego niece became as exciting and fraught with anxiety as any father's return to his doubtful child, as any husband's return to his tense wife. The anticipation period grew until it stretched from tea to the 8.0 or 9.0 p.m. arrival. Only when the niece had returned and approved could the old lady relax and be at peace.

The acute phase in which I was involved was precipitated by the nieces' going on holiday. I found an old lady whose sense of time was so disturbed that she had to check her feeling by constant reference to the clock. For so long now had the rushing minutes been checked against clock hands that stood still in the evening as she waited for the niece, and the leaden hours of dullness in the morning tallied against the measured minutes that time had lost its meaning. She was not listening properly, and once again as they must have done in her childhood, clocks and other rhythmic noises were saying things to her. She was absent-minded, whether from defective attention or retention or from emotional causes I cannot say, but so she lost her possessions. Like a child she argued that someone had taken them. What she could not *see* was, as for the young child, gone for ever, and so in the night she became disturbed by the irrecoverable loss of her necessities and treasures, her teeth, her stays, her necklace made invisible by darkness. She had digestive disturbances and haemorrhoids which gave her certain physical sensations and she, who knew the words, voiced the fantasies of the

toddler whose anus is similarly sensitive but who being less verbally fluent, can only express the erotic fantasies through dreams and play. That she spoke forth these ideas formerly shocking to her indicated a release of inhibition, a thinning of the censor that made this woman's personality level with that of the toddler of 2 months to 4 years who must continually refer to an external Super Ego figure lest wrong be accomplished and harm and punishment befall the impotent uncertain little being. So this old lady telephoned or requested me to get in touch with the police to come to the house, to keep her safe in the police station or to take action against the harmful force which she, like the toddler, externalized into a bogey man. Her extreme anxiety at being separated from her Super Ego niece was expressed in anguish such as I have seen also in the terrified toddler, and she was just as difficult to comfort through verbal means.

A certain amount of relief was obtained by carrying out the advice I would give to the mother of a terrified child. I stayed with the old lady night and day and took her in the car with me as if she had been a toddler in a push chair. When she became anguished I soothed her by holding her close to me and even rocking her. We played with the bogies: I too could make the clock say things, quite funny things that made her laugh, and I made her wait a little longer each day for satisfaction, i.e. before I conceded her request to get in touch with the Super Ego and to 'phone the police'. This was extremely exhausting, could be recommended as experience to no one because of the extravagant use of the therapist and could only be used in emergency, but it opened up channels of thought on the whole subject.

I was using child guidance methods and seemingly appropriately. Intuitively eventually I acknowledged the old lady's frequently expressed urge to 'shoot him' (the bogey man) and bought her a toy pistol with caps. She sat on the verandah for the whole afternoon practising firing. She was seriously

pleased with our mock fear (all the neighbours obligingly joined in the play), very impressed with the terrified decamping of the dog, and *for that whole afternoon she was at peace from the filthy attacks of her bogey and never once mentioned the police.*

That evening she showed a certain improvement which was maintained the next day. She seemed to doubt the veracity of her delusions and was less emphatic when speaking of them as though some of the supporting feeling had departed from them. She also took the first steps in correcting her ideas. She had for some months believed her age to be fifty. Now when asked she referred to me before replying and said puzzledly: 'You say I am 81.' It seemed to me akin to that ingestion period in the toddler who prefixes all answers or statements with 'My mummy says'. Later that same child will make with conviction the same statements without the prefix and I believe that this old lady could have reached a similar stage. However, because I was not in a position to devote further time to this one patient, she went into the mental hospital.

And I was left wondering how much of the intellectual deterioration of the aged is due really to the emotional failing. Intellectual growth is dependent upon perception and feeling, in turn based on the special (sight and sound and, to a lesser extent, taste and smell) and general (touch, pain, temperature and vibration) senses. Faulty sensory perception leads to faulty impressions and feelings and not only is the collection and storage of impressions (perception and memory) disturbed but also the additive critical and therefore reasoning components of that which we call intelligence will be impaired, less rich, less extensive, distorted. The ability to think abstractly depends on the feeling quality (the vibration, the touch or feel, the pain, the heat, the cold) supporting the concrete perceptions of eyes and ears. Anything which upsets, warps or impoverishes the feeling quality disturbs the ability to think abstractly or to think at all.

In the aged it is recognized that the intellectual powers, having declined from the height of their arc, approach those of childhood. We have possibly too readily accepted that this is due to the neurological ageing, the failing of the physical vision and hearing, the faults in the nerve cells and the association paths. Yet it is also obvious that a large part of the physical thought path becomes unnecessary sometime in adult life: special senses may be impaired, nerve tracts be damaged and still thought, and skills apparently dependent upon thought can continue at a very good level. It seems to me therefore that we should consider how much of the intellectual decline of age depends on the depression of feeling due to lack of love, or of loving response to achievement, and how much also to the loss of feeling and meaning due to the habitual practice of a skill until it is mechanical and begins through the summarizing, labour-saving process of habit to become corrupted and misshapen.

Infants and toddlers who are not 'specialled' by one person fail to develop to their full intellectual height. For this very reason there has been a great outcry against depriving a child of its mother figure even for a short spell. Such deprived children can fail to speak, or speaking, fail to learn the finer vocabulary and sentence structure; their habits can remain or become again faulty because they have no wish to please those *in authority* over them. They have no incentive to learn or develop. The young dull child who has not been loved or who has been neglected can, however, improve through the mere attendance at a Child Guidance Centre having an individual relationship with the therapist. In my early days, when I could have been of little active help to children, I remember one such dull child whose intelligence quotient after 1 year at the Clinic (twice weekly sessions) improved by 30 points.

It may be that the failing intellectual powers of the aged are dependent upon two main things: the physical state (of variable importance) and the emotional decline, and

the latter is not only due to the love deprivation but in part to the habitual living. It should be remembered that habits originated in meaningful, feelingful voluntary acts which from practice become divested of thought and feeling and may even become mere vestiges of the original act if practised often enough. So 'thought' may really be vestigial in age from habitual thinking patterns and reaction patterns. Much preventive work is being done by encouraging those retiring to take up a new life with new feelingful, thought-out voluntary acts to become new habits of living. In the child it takes from 2 to 5 years to settle the little being into its new walk of life so that it can work its body for itself, speak the language, move freely and control itself. It takes roughly about the same length of time to get established into young adulthood. The changes in both instances are physical but they involve the learning of new skills and a settling of feeling. If plans are made for the same length of time of unsettlement in those about to retire and acquire new ways of life, changes can be made in all the ageing, even radical ones and even in the seventh and eighth decade in my own experience.

The difficulties are the more intense depression and anxiety, and the lack of an actively loving outside being who will lead on the aged infant in this new sphere. Emphasis should be laid on the adjective active. Love, or its semblance 'interest' must be alive, active and meaningful for it to be efficacious. Unfortunately even loving can become habitual and the mechanical practice of the pecks of affection will not save an intellect or lead the learner on in a new field. These difficulties could be combated and a 'mothering' service provided by a Geriatric Guidance Clinic run on the same lines as a Child Guidance Clinic with a psychologist to assess the innate possibilities and the present intellectual and personality structure, the social worker to investigate the emotional forces around the patient, and if necessary modify them, and the psychiatrist to assess the physical state and to sustain the person

during the depression and anxiety by emotional support where necessary augmented with drugs or hormones.

But it would seem that the aged can suffer in the same way as children from emotional deprivation and neglect or by wrong emotional forces directed at them or surrounding them. They become as little children terrified with various or particular bogies which, being better verbalized, are called delusions but are the same stuff as dreams are made of and children's nightmares in particular. These aged sufferers, with their veneer of civilization wearing thin, let out those motives and urges that have been repressed even as the child with its developing, still thin censor cannot keep down its primitive trends. I do not know which has the greater intensity, the child's expression with all the force of the whole little being behind it or the aged's expression with the force of years of repression behind it.

The aged, then, can dwell in fantasy, can indulge in forms of masturbation and can be absorbed by antisocial tendencies which can be translated into symbols and projected, and disturb by day and night. And because of this, child guidance methods, if modified to the different skills, intellectual and physical development, could be used to help the aged not just to recover from an acute state but to grow anew. Part of child guidance therapy is cathartic, a release mechanism. The swearing, destructive or overfearful child is given a gun and plays highwayman, or with soldiers and realistic noises lets out the emotional energy turned in on himself or out against the wrong thing. This play method, possibly modified by the adult play technique of Maxwell Jones, could in a Geriatric Guidance Clinic not only release the aged from their terrors, satisfy their decades-old desires, release their life-sentenced inhibitions and counteract the spiritual expression of physical changes, but could also be a re-education measure. My old patient learned to use her right hand in a new way (Tchekov wrote a one-act play, The Bear, on the difficulty of learning

to fire a pistol); she could have gone on through target practice to re-educate hand and eye, even hand, ear and eye, and so from timing to feeling of time itself and all to shoot her bogey. The psychiatrist would need to analyse in each patient what main force was repressed, what expressions were dependent upon physical changes, what form of play therapy embodied all these factors and how to use this play not only for the release and satisfaction of the emotional state but to re-educate the perceptions, the feelings and so the 'senses' or the five wits of which these poor souls have taken leave. The sand tray and the blackboard, the clay bin and the paint pot, puppetry and costume provide thera-peutic outlets for these physically limited people even as they do to children who, be-cause of their intellectual limitations, cannot express in speech or satisfy in the sublimatory forms. Doing 'big ones' in the shape of brown houses on a blackboard for the approval of the therapist can be of comfort to the aged with bowel dissatisfaction and lead on to a new skill and interest in art.

In hospital my emotionally disturbed, deluded, hallucinated old lady with deterior-ating habits (she spat, washed as a routine and not from need, and did not notice the mess she left), would have had appropriate and readily varied drugs, and removed from the unsatisfying sentimental relationship her emotional state could have been more readily directed by the Super Ego constellations into smoother channels. Eventually she would have (as she apparently did) recovered to a calmer, undeluded state. But is that all we should ask for as physicians? It would seem that in this age of guidance clinics there is a need for the Geriatric Guidance Clinic. These can by re-assessing and directing the older person into new walks of life, and by correct-ing faulty environmental forces, actively *prevent* deteriorations and psychiatric dis-turbance in the aged and they can by treat-ments analogous to those in Child Guidance Clinics treat the psychiatric conditions of the aged which resemble those of childhood temper tantrums, the 'bogey man', jealousy situations, states of lostness and depression, masculine and feminine protests. In both children and the aged the environment is of great importance; in both, drugs and hor-mones can be efficacious; in both, verbal psychotherapy is unsatisfactory and of little help to the patient; and both are relieved by putting the whole of themselves into and act-ing out their urges and motives in relation to one particular person.

So humbly I, a child psychiatrist, put these thoughts before the geriatric psychiatrist, for this approach, though time-consuming at the moment, could lead to a preventive scheme and a scheme of out-patient treatment which could re-educate the aged to a mentally healthy existence, enabling the person to function as a loving and useful individual and citizen until his physical life ceased.

Both aunt and niece have died, the latter suddenly of a coronary thrombosis. Post-humously I would like to express my gratitude for permission to publish, which because of her scientific approach to life, the niece would certainly have given.

Treatment of the couple by a couple

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I. INTRODUCTION

Much has been written about treatment of the marital couple by a single therapist (Martin & Bird, 1952; Mass & Maloney, 1958; Gullerud & Harlan, 1962; Haley, 1963) but little work has appeared concerning four-way interviewing (Dicks, 1953; Ackerman, 1959). We believe that this technique is being used more than one would expect from a survey of the literature, and that the difficulties encountered in devising a theoretical framework for the treatment of the couple by a couple may be responsible for the scarcity of reports. Four-way interviews are often considered to be helpful only occasionally during the course of treatment in which both partners are seen regularly by individual therapists. A possible explanation for the apparent lack of interest in this method lies in psychiatrists', psychologists' and social workers' traditional preference for working alone with their patients. Some of their reasons for this preference are expressions of lack of self-confidence. A four-way therapeutic situation may be experienced as a threat by those who are usually reluctant to show their inner doubts to their patients, to their colleagues or to themselves.

We intend to present here a tentative formulation of the dynamics which govern the use of the four-way interview as a treatment of the marriage couple.

We believe that four-way interviews represent a useful way of helping people work out both their intra-personal and inter-personal problems. In contrast to the more recently established and therefore weaker one-to-one relationship with a therapist, four-way interviews afford a powerful means of tapping the already present strengths of an older relationship in order to solve current difficulties. Furthermore, evidence of marital problems is not the only indication for marriage therapy of this kind. We believe that this type of marriage therapy is also a powerful technique for the treatment of various individual disorders because of the use which is made of the marital relationship and the influence of each of the partners upon the other as a therapeutic agent. The technique places the strengths and assets of the marital relationship at the service of the therapeutic aim of communication. Our ultimate goal is to help each partner to act, at least partly, as a therapist for his or her spouse.

Material for this presentation was gathered while working with couples as part of a psychiatric consultation service for patients admitted to a general hospital for extended medical evaluation. Most of our patients do not seek out psychiatric help for their predominantly physical symptoms, nor do they necessarily define their marriages as major stress areas upon initial contact with the psychiatrist. However, when, in the routine process of interviewing the patient's spouse as part of the psychiatric consultation evaluation, long-standing marital problems are discovered, those partners may be seen subsequently in extended four-way therapy. In other cases, the marital problems to which our attention is drawn may be the recent, immediate result of the patient's physical disease and will appear as the inability of either the patient or the spouse or both to adjust themselves to the new situation. Inevitably this lack of adaptive capacity

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usually brings out all the areas of mal-adaptation of the couple.

II. Description of the Therapeutic Tool

Four-way interviewing is a method used for the study, diagnosis, and treatment of the marriage couple. The tool through which the interviews function is made up of the relationships between and among the therapeutic couple and the pathological couple. Weak or pathological as it may be, the relationship between the husband and wife is brought to the interview in an already well-established form, but it also comes with strengths and assets of its own, apart from the assets of the individuals of which it is composed. This view has been well stated by Ackerman (1959, p. 151): 'A relationship represents more than the sum of two personalities. A new level of organization creates new qualities. A marital relationship, like a chemical compound, has unique properties of its own, over and above the characteristics of the elements that merge to form the compound.' The therapeutic couple can make use of the positive forces in order to search for and to eradicate the negative or destructive elements which are at the root of their difficulties. The capacity of the therapeutic couple to speak openly and freely in front of the pathological couple serves as a model from which the pathological couple can gain insight into their own communication difficulties. This process is not characterized by an agreement between the two therapists on 'what to do' during each session, but only represents an agreement to investigate and to make clear those areas of conflict which will help the pathological couple to solve their own problems. It can lead to open censorship or to conflict between the two therapists while the interview is in progress. This conflict is only helpful if it is dealt with as immediately and as openly as possible.

Just as the marital couple comes to the treatment situation with a well-established pattern of relationships, so does the thera-peutic couple, to some extent at least. Essential to the success of this process is sufficient trust in the relationship between the therapeutic couple. Their relationship must, therefore, be examined just as carefully as the relationship of the pathological couple. In particular, it should be as free as possible from neurotic acting-out or inhibitions. The relative absence of neurotic symptoms, along with the therapists' ability to talk freely to one another, are the main criteria for estimating how successfully the therapists' libidinal and aggressive trends towards each other are being sublimated. The efficiency of the therapeutic procedure itself is directly related to that of the therapist's sublimations.

One might expect marriage counselling by more than one therapist to be more complex in some ways, owing to the six-way transference phenomena. This problem will be discussed in some detail later on. In other ways there are distinct advantages in having two therapists present. The pressure experienced by the therapists is reduced since they share the strain of the pathological couple's dependency. In addition, the therapist who is silent is able to check on the perceptions of the therapist who is speaking. This check permits both therapists to respond more freely to whatever is going on in the interview situation itself. What one therapist may fail to notice in the couple's (or his own) responses the other may perceive. This process in itself tends to make communication smooth and free. Furthermore, as contrasted to one-to-one interviews, the four-way interview gives a more accurate picture of the dynamics of the marital couple. This increased accuracy is due to the fact that in the four-way interview each therapist's view is constantly contrasted with his (or her) colleague's. This cross-checking helps both therapists to adapt and react both faster and more smoothly.

In order to be successful, four-way interviewing need not contain a treatment goal requiring implicit or explicit encouragement from the therapists to the couple to stay together, to separate, to divorce, etc. B

contrast, Gullerud & Harlan (1962) restricted their experience to couples who 'appeared to be strongly motivated to keep their marriages intact' (p. 533). Their therapeutic mission was quite obvious to all four participants: it was precisely defined and structured within the goal of preserving the marriage. We think there are definite advantages in staying neutral and thereby allowing the pathological couple to make their decisions regarding their marriage or whatever problem they are being treated for. Otherwise, free communication is more difficult and may be interrupted by pressure from any of the four members to achieve or to defeat the pre-arranged goal. Our only treatment aim is to investigate and to remove obstacles to the expression of feelings and thoughts in order to allow more complete communication. When this aim is achieved, each partner has become more able to manage his own and his partner's problems.

Our formulations are based on therapy with a husband and wife by a male and a female therapist. However, our experience of four-way interviews with different therapists led us to believe that the sex of the therapists is of much less consequence than is their personality. This opinion differs from that of Gullerud & Harlan, who considered that 'individual interviews with a worker of his own sex are particularly helpful to the client in cases in which husband and wife have conflicts in their sexual identity'. Furthermore, Gullerud & Harlan's four-way interviewing was structured within the framework of 'marital counselling' and they did not make systematic use of transference interpretations, as described below. As soon as this therapy is focused on the transference manifestations, it is evident that the sexual identity of the therapist, as it is projected on to him by the patient, overshadows his actual identity.

III. Description of the method

Each member of the marital couple is assigned an individual therapist: therapist A

to patient A', therapist B to patient B'. Each patient is seen by his individual therapist for an average of two interviews before the four-way interviewing is started. The therapist who handled the diagnostic procedure with the patient (the partner who is hospitalized) continues with him (or with her). The goal of the initial individual sessions is not to reach an objective understanding of the marital situation. Each therapist's concern, at that point, is to understand his patient's subjective view of the marital situation and to relate it faithfully to the point of actually feeling like his patient. He is aware that this attempt may result in over-identification with his patient. The initial over-identification does not concern him since he knows that the other therapist is at the same time going through the same process with the spouse, and that both identification processes will counterbalance each other when the therapists espouse the marital partners' quarrel. This characteristic, incidentally, is one of the definite advantages that four-way interviewing has over the usual type of marriage counselling (Martin & Bird, 1952): it permits both therapists to have a more relaxed attitude all through the treatment, to make better use of their emotions, and to increase their efficiency. The resulting fatigue experienced by the therapists is decreased by a coefficient which is probably greater than the number of therapists involved.

Initially, our ignorance and consequent feeling of insecurity led us to discuss our patients after our private interviews with them. We soon found out, however, that the proper place for this discussion was in the four-way interview itself.

We are now ready to proceed with the four-way treatment itself. It must start before our respective patients have had time to form too deep an attachment to their therapists and yet have reached the point where a trusting relationship has been established, even though a superficial one. Weekly joint sessions are regularly scheduled and maintained as the expected and predominant form of therapy.

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They are conducted over a period of two to three months. The therapists' immediate goal is to reach a deeper understanding of the dynamics of the group and of the four couples of which it is composed. This understanding will be accomplished by the consistent use of transference interpretations at all levels (that is, toward any one of the four couples) and in all directions (at any one of the four individuals) (See Fig. 1).
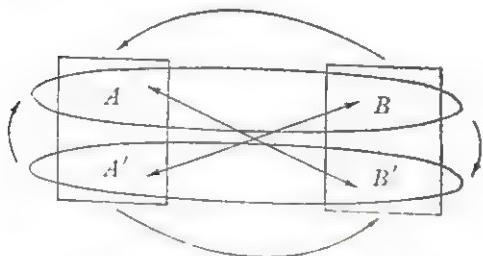

Fig. 1. A and B, therapists; A' and B', marital partners.

The word 'couple' is used here in a strictly dynamic (that is non-static) sense for the purpose of the description of the four-way interview.

The four couples are made of AB, $A'B'$, AA', BB'. As the treatment progresses, two more virtual couples will be added, i.e. AB' and $A'B$. AB and $A'B'$ are the 'stronger' couples from the point of view of the dynamics of the situation: they alone existed before the treatment was started.

Increased communication resulting from a deeper understanding of the relationship of the marital couple is the ultimate goal of the treatment. It is achieved by means of the dynamic interaction of one couple over another and through the perspective that this multi-dimensional process offers to the four individuals involved.

(1) For example, as a start, therapist A may state for his patient the patient's point of view. B will then give the spouse's answer. At this point it is useful for B not to have been informed privately by A of the content of the individual sessions. B' will thus be given an opportunity to contrast his (or her) own response to that of his (or her) therapist, thereby already gaining some insight.

(2) Soon B' will be addressing himself to A, this spouse's therapist. This new couple (i.e. $B'A$) will act as an intermediary in the process of re-establishing communications between A' and B'. The same can be said of $A'B$.

(3) A and B may find themselves openly arguing with one another in front of A' and B', who, likely as not, have never been able to argue constructively over that particular topic since their marriage. Thus the healthy AB relationship provides a *communication model* (*not* a marital model) for $A'B'$.

(4) Transference interpretations (i.e. directed at $A'B$, AB', AA', or BB') should precede interpretations directed at $A'B'$. By this we are implying that the most accurate and efficient means to reach and convey to the marital partners a full realization of the relationship between them lies in the therapists' making systematic use of their immediate perceptions of what is going on, in the 'here and now' of the four-way situation, between $A'B$, AB', AA' or BB'. These perceptions should be integrated into transference explanations which offer the patients a vivid picture of the relationship between their pathological symptoms and their behaviour in the four-way setting.

(5) Transference interpretations should be complemented by what one might call 'counter-transference' interpretations (i.e. about AB) in order to bring to the fore any unconscious attempts, on the part of the pathological couple, to induce the therapeutic couple to react in a way which would prevent a deeper understanding of the pathological couple's problems.

(6) Counter-transference interpretations (as described under paragraph (5)) pave the way toward a re-structuring of the four-way situation into the original 'stronger' couples' relationship (i.e. AB and $A'B'$). This re-structuring is accomplished gradually as A' and B' take over the functions of A and B and begin to communicate openly with one

another, both inside and outside the treatment situation. Termination of the treatment can then be contemplated.

(7) The process described under paragraph (6) accounts for the relative ease with which the four-way therapy is brought to termination. In contrast to the difficulties which are peculiar to the termination process in one-to-one psychotherapy, individual dependency needs seldom manifest themselves as an obstacle to termination of the four-way therapy of the couple. This phenomenon is related to the partners' new opportunity to satisfy each other's dependency needs through their newly acquired ability to communicate freely with one another. Thus, termination of four-way therapy means permanence rather than disillusionment or abandonment.

The only major termination problem that we have to deal with systematically concerns the severing of the dependent ties of the pathological couple to the therapeutic couple. These ties must be interpreted as soon as the process described (Ackerman, 1959) is well under way. Interpretation of the pathological couple's dependency on the therapeutic couple has the effect of fostering in them feelings of shame *as a couple* toward the therapists *as a couple*. Shame, when so experienced, does not seem to produce the usual depressive effect which can be expected in individual psychotherapy. It will actually bring the two partners closer together and increase their determination to help each other implement whatever decisions they have reached through the understanding they gained in the treatment. This co-operation may also be applied to the implementation of some partners' decision to dissolve their marriage.

IV. INDICATIONS FOR THE USE OF TREATMENT OF A COUPLE BY A COUPLE

(1) Treatment of a marriage couple is most successful when the two therapists feel comfortable enough with one another to express their thoughts and feelings openly, at the time they occur. Without a strong, positive relationship between them, treatment by two therapists is contra-indicated.

(2) This psychoanalytically oriented approach can only be applied when the marital partners are both relatively healthy and well-matched in their aptitude for developing insight. Otherwise they will be unable to withstand together the force of the direct interpretations which will come.

(3) Since our goal is not to unite the married partners, it is not necessary that the couple come to therapy with this idea in mind, although some couples do so.

(4) Four-way interviewing may be a more effective approach than individual sessions when adaptation rather than reconstruction is the treatment of choice. It is a faster method since it taps a pre-existing relationship in which the partners can compete for insight with each other and as a couple.

V. CONCLUSIONS

1. Intensification and acceleration of the usual psychotherapeutic processes are the main advantages of a four-way setting in which two psychotherapists treat two marital partners. More direct approaches can be used because the two partners are present and because the two therapists very rapidly and continually check and correct each other. It is easier for two marital partners to face their inadequacies at the same time and in the same situation than it is for either of them to face them individually. Instead of the usual 'I shall change when and if she (or he) changes', separately communicated to separate therapists, the two partners simultaneously and in the same arena compete with one another for insight and progress. Feelings of shame, experienced as a couple towards the therapeutic couple, also become a powerful factor in the progress of the treatment.

2. A continuous attention to the relationship between the two therapists is as important as the study of the relationship between husband and wife who are being treated.

3. In practice, the four-way situation turns out to be far less complicated than one would expect from viewing it as a six-way transference situation. Some of the factors involved seem to compensate for each other in a homeostatic way.

4. Research should be directed at an evaluation of the psychotherapeutic processes in the four-way interviewing. There is no reason to believe that this method could not be applied profitably to non-marital couples such as mother–daughter or employer–employee, or even to family therapy.

A tentative formulation is presented of the dynamics which govern the use of the four-way interview as a treatment of the marriage couple.

Particular emphasis is placed on the relationship between the therapeutic couple. Four-way interviewing of marital couples is more efficient if the immediate goal of the treatment is to reach a deeper understanding of the dynamics of the group and of the four couples of which it is composed rather than to save a marriage.

Four-way interviewing may be a more effective approach than individual sessions when adaptation rather than reconstruction is the treatment o choice.

SUMMARY

A four-way setting in which two psychotherapists treat two marital partners accelerates and intensifies the usual psychotherapeutic processes.

REFERENCES

ACKERMAN, N. W. (1959). *The Psychodynamics of Family Life*. New York: Basic Books Inc.

DICKS, H. V. (1953). Clinical studies in marriage and the family: a symposium on methods. *Brit. J. Med. Psychol.* **26**, 181–96.

GULLERUD, E. N. & HARLAN, V. L. (1962). Four-way joint interviewing in marital counseling. *Social Casework*, **43**, 10.

HALEY, J. (1963). Marriage therapy. *Arch. Gen. Psychiat.* **8**, 3.

MARTIN, P. A. & BIRD, H. W. (1952). An approach to the psychotherapy of marriage partners: the stereoscopic technique. Paper read at the annual meeting of the A.P.A., May 1952.

MASS, P. & MALONEY, T. (1958). Communication problems in an inter-agency family casework situation. *Social Casework*, **39**, 10.

Assessment for psychotherapy

A pilot study of psychological test indications of success and failure in treatment

By E. H. RAYNER* and H. HAHN†

When a patient starts psychotherapy he is invited to participate in a certain kind of relationship with his therapist, out of which it is hoped he will develop understanding of and relief from his anxieties. The patient is likely to find this strange and different from what he has experienced in the past. He, or the therapist, may be able or willing to use the experience profitability. If not, the treatment will have been a failure.

At a preliminary interview, the therapist usually considers, among other things, the possibilities of the therapeutic relationship being fruitful. To do this he will assess the patient's motivation for treatment, response to interpretation, depth of communication, and so on. The psychological tester does not usually assess the therapeutic relationship in such a direct way. But, when asked by a therapist a question such as 'is this patient psychotic or not?' he is probably being asked for help in deciding whether a patient can make use of therapy.

The psychologist's findings can thus have direct implications for the therapeutic process. And, as help to the patient lies primarily in developing a working relationship with his therapist, no matter what his presenting symptoms, so it is important for the psychologist to study the patient's test record deliberately for indications of responsiveness to therapy.

What can a psychologist say about the patient's possible functioning in therapy? Using his experience he can often pass on informative and accurate hunches to the

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therapist. But a statistical approach can also be of use; if a statistical relationship can be found between test responses and subsequent functioning in therapy, then such responses can be used to predict therapeutic functioning.

In this pilot study we merely consider two extremes of therapeutic functioning—'success' and 'failure'. We have examined the responses by a number of patients to a projective test given before treatment, and have attempted to relate these statistically to 'success' and 'failure' in later therapy.

We have not aimed at a definitive standardization of a test, but have used simple statistical techniques to clarify one way in which a projective test may be of use to a therapist. What we are interested in is the predictive value of a test; in particular, whether the human relationships envisaged by a patient in his test communication are repeated in his actual relationship with his therapist. It is this which we feel to be the main contribution of the paper.

BACKGROUND TO THE STUDY

(1) *The therapeutic setting*

The patients, all attending the Cassel Hospital, suffered from a variety of problems. Most showed psychoneurotic, some borderline psychotic, disturbances; most were in-patients, some out-patients. Individual psychotherapy was offered once to three times a week; the duration varying between three months and a year.

(2) *The observers*

The therapists all had a psychoanalytic background. The writers, both psychologists,

have a similar point of view; one (E.H.R.) is also a practising psychoanalyst.

(3) *The test used—the object relations technique (O.R.T.)*

The test involves the presentation of a series of twelve pictures and one blank card about which the patient is asked to tell stories. An account of the rationale of the test has been given by the originator (Phillipson, 1955).

The pictures are of various settings with human figures whose posture, expression and sex are equivocal, so that patients can make what they wish of them. The number of figures varies from picture to picture, as do the definition, depth of shading and colour. Thus the stimulus to which the patient responds with his stories varies in a controlled way as the test proceeds. In a full clinical assessment, analysis of the patient's stories is carried out on the basis of his response to each stimulus card. In this study we have been concerned only with the nature of the patient's stories with little reference to the characteristics of the stimulus cards.

METHOD

Two groups of O.R.T. protocols were assembled in the following way:

Each therapist at the hospital was given a list of his past patients who had been tested, and was asked to consider the therapeutic contact made, the work done, and the outcome of therapy in each case. He was asked to mark *A* against those two of his patients he considered did most in treatment and *Z* against those he felt did least. From the replies of twelve therapists, two groups of O.R.T. protocols were assembled, the one of twenty patients marked *A* by their therapists and considered 'successful' and the other of twenty patients marked *Z* and considered 'unsuccessful'. For brevity we will call these two groups *A*'s and *Z*'s throughout the paper.

It will be noted that any conclusions about success and failure in therapy rest on this classification. The justification for this crude method is a practical one—therapists could not be expected to spend a great deal of time assembling facts for a pilot study; their judgements are, nevertheless, considered ones with a basis in fact.

(1) *Description of the patients in the A and Z groups*

For brevity, a full clinical tabulation of the patients involved is not given, but the following notes will suffice:

		A group	*Z* group
1.	Sex	3 male, 17 female	5 male, 15 female
2.	Mean age	28·5 years	28·7 years
3.	Age range	20–45 years	19–41 years
4.	Social status	Wide range; mostly lower middle class	
5.	Intelligence	Not assessed; probably wide range in both groups	
6.	Diagnosis	Mostly psychoneurotics in both groups with wide range of symptoms. Some border-line cases in both groups, rather more in the *Z* group	

(2) *Derivation of results*

From a clinical scrutiny of the test protocols we eventually developed hunches about the differences between the two groups. The responses were then classified in a way which epitomized our hunches and allowed them to be statistically appraised.

On scanning the forty protocols, we realized that each person told very individual stories and an overall analysis of plots and dramas would be immensely complex. However, we noted a difference of mood between the stories of the *A*'s and *Z*'s. The *Z*'s stories were brief and undeveloped, situations were described in absolutes, and the characters did not emerge as human beings with depth of feeling, but rather as puppets of fate. Typical words which these patients used were 'can't', 'hopelessness', 'inevitability', 'in the power of', 'complete happiness', 'very superior'. The *A*'s stories tended to be longer and with

more developed plots. Their characters were more alive, worried in themselves rather than helpless, and showed greater range of feelings. Typically, these patients used more moderate wording, such as 'quite brave', 'rather naughty', 'try', 'ought to', 'think about'.

Although a word count like this might have shown statistical differences, we carried out our analysis at the level of phrase and sentence, for it is only at this level that the relationships between characters become evident; and it was these relationships that seemed most relevant to the patient's therapeutic relationships.

Five categories of response were defined. These described certain kinds of relationship, either between characters in the stories or between patient and tester. They are given in greater detail in the section of results below.

All protocols were scanned by both of us. If a phrase or sentence fitted the definition of a category, it was scored as such. We were not independent in our observations. Discussion was necessary to clarify our definitions. In most cases we found our judgements agreed, but, if not, they were excluded. By this means tables of the frequencies of the five categories of response were drawn up for the *A* and *Z* groups.

It will be noted that we had prior knowledge of whether a protocol was *A* or *Z*. In an attempt to check whether our scoring had been affected by this, and also to estimate whether our method could be passed on to other psychologists, we submitted a random selection of the protocols to an independent assessor. These results are given in a separate section below.

Such an independent assessment is very time consuming, and it was not easy to find more than one person to carry it out. This has limited the value of our study: our findings have in no way been standardized; thus our categories are only guides in a pilot study and are not applicable as clear-cut rules of thumb.

Results

(Original assessment by E. H. Rayner and H. Hahn.)

The categories of response, in two main sections—'Negative Indicators' on which the *Z*'s scored highly, and 'Positive Indicators' on which the *A*'s scored highly—are now considered.

In the following paragraphs, each category of response is given a definition, and in our scoring we adhered rigidly to these, but readers may find this study most useful if they assimilate the general idea conveyed by the definitions, rather than use them in a cut and dried way.

(1) *Negative indicators*

(a) *Non-participation*

The first category concerns responses in the protocols which convey a sense of a person's unwillingness for or the impossibility of participation in an activity. This could either be in terms of a patient speaking about a character in a story who was unwilling to participate, or by the patient himself showing similar unwillingness.

This unwillingness is conveyed in the following examples:

(1) 'Perhaps he had an appointment with this person, he has not kept it and has dashed off.'

(2) 'They say he ought to get a job, he will eventually shuffle off but not to any purpose.'

(3) 'I am rebelling; I don't want to tell you. I don't want to look at any more of these pictures. Deep down I know it's there and I'm jolly well keeping it down.'

The following definition was constructed and phrases in the protocols judged as falling within it were enumerated for the *A* and *Z* groups.

Definition: 'Non-participation'. A statement by the patient indicating that:

(*a*) participation in an activity is envisaged for a character;

(*b*) this participation is decided against, avoided by the character or made impossible for him.

The following comments are of note:

(1) the activity envisaged could be a relationship with other people or it could be solitary;

(2) the character referred to in the definition would usually be a fictitious one in the patient's story, but it could also be the patient referring to himself.

The results of the enumeration of these phrases are given after the next definition below.

(b) Passivity

In this category of response the patient contrasted the characteristics of two groups of people. The contrast we are concerned with trasting groups of people (or single persons) and that:

(a) one possesses effectiveness;

(b) the other possesses none and can make no active response (either internal or overt) but only prays, despairs or withdraws.

Notes: The keynote of this definition is the contrast of effectiveness, without qualification, between the groups. In particular, the patient gives no sign that things could possibly be different or changed; thus the passive person is given no internal strength to alter either himself or the situation.

The number of times each patient made these 'negative' responses (Non-participation and Passivity) appears in Table 1A.

Table 1A. *Negative Indicators: frequency of instances of 'Non-participation' and 'Passivity' phrases in the O.R.T. protocols of the A and Z groups*

Group		Individual patient's scores	Total
A	Non-participation	2, 0, 0, 0, 0, 0, 0, 0, 0, 0, 1, 0, 0, 1, 0, 1, 0, 0, 1, 0	6
	Passivity	1, 0, 0, 1, 1, 0, 0, 0, 0, 2, 0, 0, 0, 2, 0, 2, 0, 0, 0, 1	10
Z	Non-participation	2, 4, 1, 2, 2, 0, 2, 2, 2, 1, 0, 4, 0, 0, 2, 2, 2, 2, 1, 0	31
	Passivity	4, 4, 1, 6, 2, 1, 2, 1, 1, 1, 0, 3, 0, 1, 2, 3, 2, 2, 0, 4	40

was that which occurred when one group was described as possessing effectiveness, whereas the other was indicated as passive and helpless. The groups could be described as 'haves' and 'have nots'. Examples:

(1) 'A shadow of a figure coming down, they are cowering in terror from him, the people are in fear of him coming down the stairs.'

(2) 'Praying about themselves in church to be given some sort of solution that might answer a problem.'

(3) 'People waiting in anger to beat up this man and kill him. They will kill him.'

To cover this idea of contrast between effectiveness and passivity the following definition was constructed and phrases in the protocols judged as falling within it were enumerated for the A and Z groups.

Definition: 'Passivity'. A statement by the patient indicating the existence of two con-

Table 1B is derived from this to show the number of *patients* in the A and Z groups who use these 'negative' indicator phrases.

Table 1B. *Frequency of patients using either of these 'Negative Indicator' phrases in the A and Z groups*

Group	Uses Negative Indicator	Does not use Negative Indicator
A	9	11
Z	18	2

Applying a χ^2 test, the difference of frequency is significant at the 1 % level.

Table 1A shows that we were able to discriminate both categories of Negative Indicator phrases more frequently with the Z's than with the A's. The χ^2 test on Table 1B shows that the number of Z patients who used at

least one Negative Indicator phrase in their protocols was significantly greater than with the *A*'s. However, the frequency of this type of response is not great for each patient. Furthermore, nearly half of the *A* group used them, so that the mere presence or absence of negative indicators in a patient's protocol is not alone an adequate discriminator of whether a patient is *A* or *Z*.

(2) *Positive Indicators*

We now consider the phrases that seemed to epitomise the mood of the *A* protocols. In a general way these are concerned with either the patient, or one of his characters, having a responsible or conscientious attitude about what they are doing or feeling. Out of this general description we have defined several particular categories which are described below.

(a) *Self-responsibility*

This category dealt with responses showing a character in a protocol who is aware of his own feelings or actions in a responsible way. It could be described as a character being reflective about himself and the effect he has on others. Examples:

(1) 'She doesn't want the others to see her, she knows that she is spying on them; she should be in bed asleep.'

(2) 'He is telling them something unpleasant, I think he is troubled. He might be telling them he has failed them.'

(3) 'She couldn't really afford to go, would much rather spend the money in some other way, but then she decides she ought to make a special effort to go once a year.'

The following definition was constructed and phrases in the protocols falling within it were enumerated.

Definition: 'Self-Responsibility'. A statement by the patient describing a character in a story as being aware of and having a responsible attitude towards his own feelings or actions, in a situation of conflict.

Notes: We were concerned here with a character feeling responsibility in a situation

of conflict or difficulty. A sense of responsibility in an easy situation has not the same quality and often has a note of self-satisfied wish fulfilment.

(b) *Positive Persistence*

This category was concerned with characters being described as trying, by repeated efforts, to achieve a worthwhile aim.

The following examples will illustrate this:

(1) 'Got to start clearing this up before getting on with anything else.'

(2) 'They are going to be refused, will go away and come back and keep trying.'

Definition: 'Positive Persistence'. A statement made by the patient indicating that a character in a story is conscientiously persistent in his efforts.

Notes: The adverb 'conscientiously' is included in this definition to indicate that the character's efforts are directed towards an aim which is not detrimental to himself or to others.

The two categories of 'Self-responsibility' and 'Positive Persistence' were often difficult to distinguish. Both qualities could be indicated in the same phrases, for example: 'Groping his way along in the fog, he ought to be trying to get home but not sure whether he can manage it. He is rather worried wondering whether they will be missing him at home.'

Because of this overlapping, we combined the scores of these two categories, and they are given in the tables of results at the end of this section.

(c) *Self-appraisal*

This category was concerned with statements about the patient himself which he made while telling the stories. We often found reflective comments in which the patient related himself to what he had said in a story, i.e. he stood back and looked at himself. Examples:

(1) 'She's afraid she'll be followed, that's often how I feel, really must be how I feel.'

(2) 'A man persuading a girl to do something and she does it. Really the same sort of problem as my own.'

We constructed the following definition and enumerated phrases in the protocols that were judged to be instances of it.

Definition: 'Self-appraisal'. A statement made by the patient appraising or reflecting about himself in relation to his telling a story.

Notes:

(1) This should be distinguished from the instances where a patient simply projected himself as a character in the story of the 'that's me' type.

(2) It should also be distinguished from simple statements of intention by the patient, such as 'I can't tell you stories'.

It seemed to us that this category had the quality of responsibility or conscientiousness in common with 'Self-responsibility' and 'Positive Persistence'. With 'Self-appraisal' the patient himself accepted responsibility for his stories by seeing them as relevant to his own problems.

We have combined the results of these three categories in the tables below:

in their protocols is significantly greater than with the Z's.

A comparison of these results with those of the 'Negative Indicators' shows that the 'Positive Indicators' gave a much more clear cut differentiation between the A's and the Z's than did the 'Negative Indicators'. It will be noted that all A's used 'Positive Indicator' phrases. However, some of the Z's did also, so, in the following section, we have tried to see whether a crude combination of these two indicators provides a good discrimination between the two groups of patients.

(3) *Comparison of the scoring on Positive and Negative Indicators by the individuals of the A and Z groups*

If we expect the A's to score highly on the 'Positive Indicator' phrases, and the Z's to score highly on the 'Negative Indicators', then for any one patient the difference between the frequencies of these two indicators is an index of whether he is an A or a Z. This Difference Score can be obtained by subtracting the individual patient's scores on Table

Table 2A. '*Positive Indicators*': frequency of instances of '*Self-responsibility*', '*Positive Persistence*' and '*Self-appraisal*' phrases in the O.R.T. protocols

Group	Category	Individual patient's scores	Total
A	Self-responsibility and Positive Persistence	2, 4, 4, 3, 2, 1, 2, 2, 2, 5, 0, 1, 3, 3, 3, 1, 2, 1, 7, 1	49
	Self-appraisal	0, 4, 1, 1, 1, 0, 4, 1, 3, 4, 1, 2, 1, 1, 6, 2, 1, 1, 0, 0	34
Z	Self-responsibility and Positive Persistence	0, 1, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 1, 1, 0, 0, 0, 0, 1, 0, 1	5
	Self-appraisal	0, 0, 1, 0, 0, 0, 0, 0, 0, 0, 0, 1, 2, 1, 0, 0, 0, 0, 0, 0, 0	5

From this Table 2B is abstracted to show the frequencies of *patients* in the A and Z groups who used 'Positive Indicator' phrases.

Table 2A shows that were able to discriminate both categories of 'Positive Indicator' much more frequently with the A's than with the Z's. The χ^2 test on Table 2B shows that the frequency of A patients who used at least one 'Positive Indicator' phrase

Table 2B. *Frequency of patients using 'Positive Indicator' phrases in the A and Z groups*

Group	Uses Positive Indicators	Does not use Positive Indicators
A	20	0
Z	7	13

Applying a χ^2 test this difference is significant at the 1 % level.

1A from those on Table 2A. These individual Difference Scores are given in the table that follows:

There were practical difficulties in finding people able and willing to spend the great

Table 3. *Differences between the frequencies of 'Positive Indicator' phrases and 'Negative Indicator' phrases as used by the individuals of the A and Z groups*

Group	Individual patient's Difference Scores
A	−1, +8, +5, +3, +2, +1, +6, +4, +4, +7, 0, +3, +4, +1, +9, 0, +3, +2, +6, 0
Z	−6, −7, −1, −8, −4, −1, −4, −3, −3, −2, +1, −4, +2, −1, −4, −5, −4, −3, −1, −3

Inspection of this table shows that our Difference Score placed 34 of our 40 patients in the correct group. It placed three incorrectly and three had a score of 0. This is a considerably better discrimination than by the use of Negative Indicators alone and slightly better than by the use of Positive Indicators alone.

Now that this discrimination has been achieved, three outstanding problems remained:

(1) We had made all these measurements against the criterion of *A* and *Z*, which was derived from therapists' judgements. These may have been at fault, but the limits of this particular study made it impossible to check them further.

(2) We were aware which patients were *A* and *Z* and this knowledge may have been a factor in our scoring. Thus this pilot study must be followed by analysis of unknown cases. However, submission of these protocols to an independent assessor to score without prior knowledge gave us some means of estimating the effect of prior knowledge on scoring.

(3) Even though we were able to use our indicators to discriminate between *A* and *Z* patients, we did not know whether this method could be passed on to be used by anyone else. Here again an answer can only be given by an independent assessment of our method.

The next section of results is concerned with *our attempt to answer* problems (2) and (3) above by independent assessment.

amount of time required to score the protocols by our method, and we had to be satisfied with one assessor, who was able to score 20 of our protocols. This assessor had experience in psychometric methods but none in projective techniques. She described herself as 'sceptically interested'.

We explained our category definitions and asked her to score several trial protocols. It immediately became clear that she could not apply the definitions in a rule of thumb way. She had to convert them into abstract concepts of her own before applying them to the protocols. This was a difficult process of learning by trial and error.

When the assessor felt she had grasped the definitions, we submitted 10 of our *A* and 10 *Z* protocols which she had not seen before. They were randomized, and she did not know which was *A* and which *Z*. She scored the protocols in exactly the same way as we did.

We will concern ourselves here solely with the independent assessor's capacity to discriminate individuals as *A* or *Z* by her use of our categories. The tables below demonstrate this. For brevity we will not consider each category individually, but simply together under 'positive' and 'negative' indicators.

From Table 4A, Tables 4B and 4C can be abstracted.

These show that the assessor's scoring of 'positive' indicators discriminated the *A* and *Z* patients quite well. But, on the 'negative' indicators, she scored the *A*'s more highly than the *Z*'s. This reversal of the expected

Table 4 A. *Frequency of 'Positive Indicators' (Self-responsibility, Positive Persistence and Self-appraisal) and 'Negative Indicators' (Non-participation and Passivity), as scored by the independent assessor for the individuals of the A and Z groups*

(10 *A*'s and 10 *Z*'s were scored by the assessor. In parentheses are our original scores for the same individuals.)

Group	Category					Individual patient's scores				
A	Positive Indicators	2	2	5	8	2	3	5	4	7	1
		(6)	(3)	(5)	(9)	(4)	(4)	(3)	(2)	(7)	(1)
	Negative Indicators	4	1	1	2	1	5	2	0	2	1
		(0)	(0)	(0)	(2)	(0)	(2)	(0)	(0)	(1)	(1)
Z	Positive Indicators	0	1	0	0	0	2	2	1	0	1
		(0)	(0)	(0)	(0)	(0)	(1)	(3)	(0)	(0)	(0)
	Negative Indicators	2	3	0	0	1	0	3	2	1	3
		(1)	(4)	(3)	(3)	(2)	(0)	(7)	(1)	(4)	(5)

Table 4B. *Frequency of patients using positive indicator phrases as scored by independent assessor*

(Our original scoring in parentheses.)

Group	Uses Positive Indicators	Does not use Positive Indicators
A	10 (10)	0 (0)
Z	5 (2)	5 (0)

Table 4C. *Frequency of patients using negative indicator phrases as scored by independent assessor*

(Our original scoring in parentheses.)

Group	Uses Negative Indicators	Does not use Negative Indicators
A	9 (4)	1 (6)
Z	7 (9)	3 (1)

Table 4D. *Differences between 'Positive' and 'Negative' indicators scores for the A and Z groups, as judged by the independent assessor*

(This has been derived from Table 4A above—our original difference scores for the same patients are in parentheses.)

Group				Individual patient's Difference Scores						
A	−2	+1	+4	+6	+1	−2	+3	+4	+5	0
	(+6)	(+3)	(+5)	(+7)	(+4)	(+2)	(+3)	(+2)	(+6)	(0)
Z	−2	−2	0	0	−1	+2	−1	−1	−1	−2
	(−1)	(−3)	(−3)	(−3)	(−2)	(+1)	(−4)	(−1)	(−4)	(−5)

trend casts serious doubt on the use of 'negative' indicators.

In our original scoring the use of the combination of 'positive' and 'negative' indicators made for slightly better discrimination of A and Z than if the 'positive' indicators were used alone. So, we will consider the difference scores between 'positive' and 'negative' indicators in the same way as was done in Table 3 above.

If we consider the degree of agreement between us and the assessor, it will be seen that there were two absolute disagreements in the sign of the difference scores between us. Also there are two cases which she scored as 0 and which we scored as 'negative'. If we

are strict and include the latter as disagreements, then there were 16 agreements out of 20 between us and the assessor.

If we compare her scoring of differences against the criteria of the A and Z groups, then Table 4D shows her placing 14 patients out of 20 in the correct group (3 are incorrect and 3 scored as 0). As we would expect 10 patients to be placed correctly by chance allocation, this is not very good. Furthermore, referring back to Table 4B, it will be realized that by using the 'positive' indicators alone she would have been correct in her allocation to A and Z groups in 15 cases out of 20. Thus we must conclude that her use of negative indicators added nothing to her discrimination.

We wondered whether a less mechanical method of appraisal would produce a better discrimination, so, finally, we gave the assessor all 40 A and Z protocols (20 of which she had seen for the assessment described above). She did not know which were A or Z, and we asked her to sort them into these two groups, using the concepts she had learnt from us in as free a way as she wished.

By this more clinical way of using the concepts she was correct in 32 cases out of 40.

Conclusions from the independent assessment

These results simply indicate how far we were able to pass on our ideas for one other psychologist to use.

It has been shown that a fair measure of agreement in the overall scoring of whether a patient was A or Z was reached between us and the assessor. More particularly, a fair measure of agreement was reached in the use of the 'positive' indicators but not in the use of the 'negative' indicators.

Discrepancies between the two assessments could be due to one or both of the following errors:

(1) That we used signs in a protocol to discriminate a patient as A or Z which were not formalized in the definitions and were not communicated to the assessor. Included in this error would be the possible use by us of the knowledge of whether a patient was A or Z. Also included in this would be the factor of inadequate definition of the categories.

(2) The assessor may not have used the concepts passed on to her in the way instructed.

With this analysis it is impossible to say which of the sources of error was the greater. It must also be stressed that this study only gives an indication of how we were able to communicate our method on this restricted set of protocols to one individual. With other assessors and other protocols the results might well be different.

We can only say that some measure of success in communicating the method is possible. This is particularly so in the use of 'positive' indicators.

Discussion

(1) We found significant differences on both 'positive' and 'negative' indicators between those 'successful' in therapy and those who were not.

We were able to pass on the concepts concerned with 'positive' indicators to an independent assessor with some success. But difficulties arose in the use of 'negative' indicators.

Thus it seems likely that the best approach to develop in future work in finding prognostic signs on the o.r.t. for psychotherapy will be concerned with these 'positive' indicators.

In general, this study suggests that from examination of o.r.t. protocols it is possible to predict something of the later therapeutic interaction. This is the main point of our paper, for as far as we know, this use of testing has not been investigated before. We will therefore discuss it in some detail. To prevent misunderstandings at a theoretical level, we will avoid the use of the nomenclature of any particular theory (such as psychoanalysis).

We think that this possibility of prediction is not fortuitous but can be understood in

terms of the patient's capacity for and difficulties with human relationships. For this it is useful to take the following point of view:

When a patient comes to do the o.r.t., the interview and stimulus cards have been structured to emphasize human relationships. Thus the patient communicates, through the content of his protocol, his feelings about human relationships. Then, when he goes on to therapy, he participates with the therapist in ways which are characteristic for him and which he has already indicated in the test communications.

Our 'positive' and 'negative' indicators described certain kinds of human relationships which by our hypothesis we would expect to be repeated in therapy.

We will now discuss the relationships involved in our categories in order to see what relevance they might have to therapy. We will start with the 'negative' indicators, remembering, while we do this, the qualifications cast upon 'negative' indicators by the independent assessment.

(2) *Non-participation and therapy*

In this category, a character envisages participation in an activity but decides against it, avoids it, or the activity is made impossible.

If a patient tells stories of this nature, we would expect him to be prone to decide against, avoid or make therapy impossible. We would not necessarily expect him to be a 'failure' in therapy from the mere presence of these stories. Other stories on the o.r.t. showing human relationships of quite different propensities for a therapeutic relationship. However, our high scoring of the Z's (or failures) on this category suggests that they were hinting that they would fail, avoid or make impossible the therapeutic relationship which was being offered to them.

(3) *'Passivity' and therapy*

This category is concerned with stories where there is a contrast of characters, those that possessed effectiveness, and those that did not.

For patients where features of 'effectiveness passivity' appear in their stories, we would expect the same features to re-occur in the therapeutic relationship. At any moment in time, the therapist of such a patient would be cast into one of these contrasting roles and the patient in the other. These roles could change but the contrast would remain as these alternatives show:

(1) If the patient feels himself a 'have not' then the therapist will be experienced as withholding effectiveness from him.

(2) If the patient feels himself a 'have' the therapist will be useless.

(3) If the patient feels a victim, the therapist will be a persecutor.

(4) If he feels a persecutor, the therapist will be a victim.

Whichever of the alternatives is predominant, it is clear that participation in work together would be virtually impossible. Many therapists would say that an experience like this is common enough, and, if not modified by milder and warmer feelings in the patient, is notoriously hard to handle. It will be noted that we found a greater frequency of response like this with the Z's than with the A's.

(4) *'Positive Indicators', 'Self-responsibility', 'Positive Persistence', 'Self-appraisal' and therapy*

These were the categories of response which provided the most striking differences between the A's and Z's, both for us and the independent assessor. This showed how much more frequently the A's spoke of characters who were reflective, persistent, and had a sense of responsibility about their feelings and wishes.

If such themes represent how a patient can feel in a situation of conflict, then we would expect this to be repeated with his therapist. Thus the patient would be able to use the functions of reflexion, persistence and responsible awareness in the therapeutic process. The very process of therapy is often considered as a gaining acceptance of responsibility for ones own feelings and

wishes; this is often abbreviated to the concept of 'insight'.

Our findings suggest that something akin to 'Self-responsibility' might be of critical importance in the success or failure of therapy as we now practise it. How such a function manifests itself in a patient's communications, other than on the O.R.T., is an open question.

(5) *Further considerations concerning 'Self-responsibility'*

From the discussion above, it seems that, to function in a 'Self-responsible' way, the patient must use a certain structuring in his mental activity when relating to the therapist. Such a structuring would have the following characteristics:

(1) An organization within the patient's mind which critically evaluates his feelings and wishes.

(2) This organization must itself be acceptable to the patient as part of himself.

Another way of putting this would be to say that the patient must have some capacity to experience and use self-criticism in a mild and helpful way. It seems that the activity of a mild conscience is an important factor in therapy.

This might lead us to surmise that it is only the less ill people who can fruitfully participate in psychotherapy. This would be premature because the fact that a patient has some capacity to experience mild self-criticism does not mean that he may not be very ill with regard to many aspects of his functioning. We have not attempted to correlate success in therapy with the severity of presenting illness. Our impression is that there is no simple one to one relationship.

(6) *The inability critically to evaluate feelings and wishes*

We have already noted the Z's incapacity to represent this function on the O.R.T. and how it is likely that they cannot tolerate self-evaluation in therapy. We suggest that this self-evaluation cannot operate effectively in

therapy because of the severity of the criticism it would engender. Some instances of Z stories which do show 'Self-responsibility' suggest that this might be the case. For example:

(1) 'My God, my God, why did I ever marry you? It's wicked that I am so wicked.'

(2) 'He's committed a murder in a fit of passion; he's now regretting it.'

(3) 'This person took her own life; they all feel sorry about it, feel they had something to do with it.'

These all show an extreme self-criticism or guilt which would be experienced in therapy as a very persecuting relationship with the therapist. Such a patient might then fall back on the attitude epitomized by 'passivity' which denies responsibility for himself.

(7) *Conclusion*

We have studied two extreme groups of patients and used their test responses to epitomize success and failure. The presence of 'negative' indicators in the A's protocols and 'positive' indicators in the Z's suggest that a patient is neither all good or all bad for therapy. It seems likely that every person, let alone patient, experiences certain relationships in any of the ways we have described. The task of the tester is to assess the relative importance of each type of function in a patient and forewarn the therapist about them.

With regard to forewarning or predicting the therapeutic possibilities for a patient, we feel that this study emphasizes the importance of considering his positive capacities in a therapeutic relationship, rather than the negative or ill ones. We suggest that the study of such a function as 'Self-responsibility' in the therapeutic relationship is important in estimating a prognosis. Our terminology is not necessarily the best one, nor do we think we have done more than approach the study of a patient's positive capacities.

In a more general way we feel that, for the psychologist, this study shows how he can be helpful to a therapist by forewarning him

about the therapeutic relationship. For the therapist, we feel this paper shows one way in which psychological testing may be useful to him, and also how simple statistical analysis on a fairly large number of patients can help in clarifying the everyday problems of the therapeutic relationship.

REFERENCE

PHILLIPSON, H. (1955). *The Object Relations Technique*. London: Tavistock.

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Bernard Shaw and his women

By LISBETH J. SACHS* and BERNARD H. STERN†

G. B. Shaw is noted in the world of dramatic literature as a satirist and social critic, a social philosopher, 'the virtual creator of modern comedy of ideas' (Gassner, 1960, p. 539), and 'the one giant dramatic talent of England since the Elizabethan period' (Clark & Freedley, 1947, p. 177). In addition to the 'Shavian sense of fun, anticlimax, and superficial blasphemy, his work retains what G. K. Chesterton called "the virginity and violence of Ireland...a strange purity and a strange pugnacity"' (Magill & Kohler, 1958, p. 965). In 1915 Ludwig Lewisohn called him 'a writer of comedy with a tragic cry in his soul. In the middle ages he would have been a great saint, appalled at the gracelessness of men's hearts, militant for the kingdom of God. Today he is a playwright, appalled at the muddle-headedness of the race, a fighter for the conquest of reason over unreason, of order over disorder, of economy over waste' (Gassner, 1960, p. 539). 'So much is known and not known of the man that we are clearly informed of all his opinions whether we agree with them or not, but of his personal life and motivations of being we are still lamentably unserved' (Clark & Freedley, 1947, p. 168).

Little serious attention, for example, has been given by the literary critics to his relationship to women because of the presence of so much Shavian wit, showy verbiage, and the soft pedalling of his official biographer. It is most hostile as seen in both his biography and his work. That this attitude, as expressed in his views on marriage, love and sexual relations, is a result of his childhood relationship with his mother may be observed in Shaw's own statements and in those of his biographers.

Shaw said: 'I should say she was the worst mother conceivable....Oh, a devil of a childhood, rich only in dreams, frightful and loveless in reality....We children were abandoned entirely to servants who...were utterly unfit to be trusted with the charge of three cats, much less three children. I had my meals in the kitchen, mostly of stewed beef, which I loathed, badly cooked potatoes, sound or diseased as the case might be, and much too much tea...left to draw on the hob until it was pure tannin' (Ervine, 1956, pp. 17–18). This last remark might, incidentally, explain his not eating meat or drinking tea in later life, though he explained his vegetarianism as medication against severe headaches from which—interestingly enough—he suffered regularly once a month.

His biographer enlarges on his childhood:

These children had no love from their mother, who felt such contempt for her husband that she may have withheld her love from them because they were his. The fact that her son physically resembled his father seemed to make her more antipathetic to him than she was to his sisters. [His mother left young Bernard behind with his father when she followed her lover to London, although she took her two daughters with her.] G.B.S. asserted that he had been begotten after a brawl, when his father was fuddled with drink. If this were true, his conception must have been a humiliation to the proud, hard-natured mother. ...The cold, hard young heart [of the mother] became colder and harder after marriage to the drunkard...unforgiving if an offender overstepped a certain line...She was...not quite human, and in later years her son would sometimes wonder how she ever managed to become the mother of three children....She was a cold

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woman with a deep aversion from all demonstration of affection, her natural dislike of such demonstrations intensified by her deep disdain for her shiftless husband and her disgust at the thought that she had conceived children by him. It turned her away from her son and daughters as surely as it turned her away from her husband [pp. 18–20]. His sister Lucy called the mother 'shrewd and fearless, but difficult to love'.

She was a 'firm-minded and emphatic mother', in contrast to 'the easy-going and unassertive father' who was given to heavy drinking.

Even as an octogenarian, Shaw still remembered his childhood unhappily: 'The way we were brought up, or rather not brought up, doesn't bear thinking of....I was taken— and took myself—for what I was...a disagreeable little beast....I hadn't even common self-respect....My shyness and cowardice have been beyond all belief.' Here Shaw realizes that he saw himself through the eyes of his mother and relates his lack of self-respect to his mother's upbringing of him.

Shaw himself was aware that his inability to love was due to his mother's lack of giving love: 'The fact that nobody cared for me particularly gave me a frightful self-sufficiency, or rather a power of starving on imaginary feasts, that may have delayed my development a good deal, and leaves me to this hour a treacherous brute in matters of pure affection....[My mother's] almost complete neglect of me had the advantage that I could idolise her to the utmost pitch of my imagination and had no sordid or disillusioning contacts with her' (Pearson, 1950a, p. 4).

The sordidness and disillusions which he associates with possible contact with his mother certainly point to a cold, harsh, and ungiving attitude by the mother. After his mother's death, he described her cremation:

Why does a funeral always sharpen one's sense of humor and rouse one's spirits? This one was a complete success....Since I could not have a splendid procession with lovely colors and flashing life and triumphant music,...I, hard as nails

and in loyally high spirits (rejoicing irrepressibly in my mother's memory),...went behind the scenes at the end of the service and saw the real thing....It is wonderful....The feet burst miraculously into streaming ribbons of garnet colored lovely flame, smokeless and eager, like pentecostal tongues, and as the whole coffin passed in, it sprang into flame all over; and my mother became that beautiful fire.

(Dent, 1952, p. 52.)

Certainly only a man 'hard as nails' can 'rejoice' and be 'humoured' by his mother's cremation; certainly his 'rejoicing' and his high 'spirits' and 'sharpened sense of humor' can only be produced by his hatred of his mother. The fact that he singles out her burning feet as the most noticeable part of her body makes one wonder if he unconsciously equates feet with penis and sees her as a phallic woman.

Let us now look at Shaw's relationship to the women in his adult life as seen by his biographers. Shaw's showy verbiage and witty 'line' were used with irresponsibility and unconcern for their feelings, with a great deal of hostility, on every woman with whom he flirted, and he flirted with and teased almost every woman he knew. The effect of his behaviour toward these women was frequently frustrating, painful, and even tragic. They were not so easily satisfied as he was with passionate words, and his hostility, coated with wit and blarney, hurt them deeply. Thus, he wrote love letters to Annie Besant, the orator, and led her on to serious love for him. When he refused to marry her, she became severely depressed and attempted suicide. Interestingly enough, her depression was accompanied by sudden greying of her hair.

He stimulated and encouraged Edith Nesbit Bland, the wife of one of his socialist colleagues, to the point of writing love poems to him which he treated with complete unconcern for her feelings. She called him untrustworthy 'because he repeated everything he heard and embroidered the truth' (Pearson, 1950a, pp. 93 ff.).

His teasing of Eleanor Marx, the daughter of Karl Marx, resulted in her running away with the scamp Edward Aveling on the rebound and her eventual suicide. But the most infamous of his 'love' affairs in passionate words he carried on with Mrs Patrick Campbell. He called her his 'Stella Stellarum, his glorious white marble lady, his Beatricissima'. 'His love', he said, 'was everlasting and undying.' When, however, he heard of her death, he wrote: 'Everyone is greatly relieved' (Kilty, 1960, p. 9). In the meantime, during the period of his 'wooing' her, he subjected her to prolonged sadistic emotional beatings.

The correspondence between these 'lovers' involves hundreds of letters of the most emotional and excited kind. The letters illustrate both Shaw's empty though superficially impassioned 'line' and Mrs Campbell's sincere though unfulfilled love in all its phases from arousal through longing through frustration and disappointment to despair. Here are some selections from the letters. In one of them he calls himself an actor though he never appeared on a stage, which makes us feel that he was well aware of his insincerity:

HE: What's the matter? Are you afraid you might involve your heart with this unregenerate socialist and actor...as he has with you? Or are you afraid you won't?

SHE: Beatrice Webb is right, you are a sprite. And how can one fall in love with a sprite? Will you come on Friday and I promise we can be *alone*!

HE: I could not love thee, dear, so much, loved I not money more! [Observe how, in this play on a well-known phrase, his anality shows.]

SHE: Oh, Mr Shaw, you're such a clown! I think I'll call you 'Joey'—'Joey the Clown'.

SHE: Oh, darling, what a letter! I call you 'darling' because 'dear Mr Shaw' means nothing at all—whilst darling means most dear and most dear means a man, and a mind and a speaking—such as you and your mind and your speech!

HE: I wish I could fall in love without telling everybody. I shall be 56 on the 26th of this month, and I have not yet grown up. I must go now and read this letter to my wife, Charlotte. My love affairs are her unfailing amusement. Besides, I love an audience.

SHE: Oh, darling! It's too late to do anything but *accept* you and *love* you—but when you were quite a little boy somebody ought to have said 'hush' just once....These letters of yours are traps—traps like your Irish accent.

HE: Oh! you are right! Shut your ears tight against this blarneying Irish liar and actor. He will fill his fountain pen with your heart's blood, and sell your most sacred emotions on the stage.

SHE: You don't really think that I believed you came to see me because you were interested in me. I knew it was Liza...[the lead role in *Pygmalion*]. I haven't said 'kiss me' because life is too short for the kiss my heart calls for.

HE: Oh, you must, you must be torn out of your bed and shaken into rude health. Or else I will get into the bed myself and we shall perish together scandalously....Yesterday Charlotte overheard our telephone conversation and the effect was dreadful; it hurts me miserably to see anyone suffer like that....I throw my desperate hands to heaven and ask why one cannot make one beloved woman happy without sacrificing another. [Note how this contrasts sharply with his previous comment that Charlotte is unfailingly amused by his love affairs.]

HE: You have wakened the latent tragedy in me, broken through my proud overbearing gaiety that carried all the tragedies of the world like feathers and stuck them in my cap and laughed. And if your part in it was an illusion, then I am as lonely as God. Therefore you must still be the Mother of Angels to me, still from time to time put on your divinity and sit in the heavens with me. For that, with all our assumed cleverness, is all we two are really fit for. [Is this perhaps an admission of his impotence? Does he want the role of God and Mother of Angels for himself and Mrs Campbell instead of that of man and woman?] Remember this always, for in this I am deeply faithful to you...faithful beyond all love. Be faithful to me in it and I will forgive you though you betray me in everything else—forgive you, bless you, honor you and adore you....For you I wear my head nearest the skies.

SHE: Oh, Joey! If I could write letters like you, I would write letters to God.

(Kilty, 1960, pp. 17–46 *passim*.)

In desperation and disappointment, after 16 years of being fooled by Shaw, Mrs Campbell proceeded to marry the flighty

George Cornwallis-West in 1914, when she was 49 years old. The marriage lasted only a few years.

Shaw told Lady Astor at a later date that the following colloquy took place between him and Mrs Campbell:

STELLA: Next time you try to fascinate an actress, don't use her as a means of teasing Charlotte...that was the ugliest thing you ever did.

He hit her right back, implying that she had hostile motivations, that is, projecting his hostility on to her:

The moment I discovered that Stella merely wished to humiliate Charlotte by winning me away from her, I was through with Stella.
(Henderson, 1956, p. 830.)

Shaw's marriage was no marriage at all but an arrangement for mutual convenience without any emotional links and without sex. After his wife's death, Shaw claimed that he knew nothing about marriage, since he had never been married as commonly understood. 'Shaw's marriage to Charlotte in 1898 was a business partnership....Absent was any physical demonstration of affection: neither kisses, embraces, nor any physical contact whatever.' Shaw's official biographer, with Victorian sentiments slanted by Shaw's own indoctrination, considered such a relationship an 'ideal marriage'. But is it not a cold, ugly and hostile relationship when a husband presents his love letters, meant for another woman, to his own wife to read, and, according to his own admission, makes her 'suffer dreadfully' because he 'loves an audience'?

On the day of his wife's death, Shaw paid a visit to his friends, the O'Connells.

He looked his normal cheerful self, and for some time after his arrival he discussed questions of copyright....Breaking off suddenly, he said:

'Do you or Eleanor notice anything different about me?'

'You have new shoes on,' guessed Wardrop.

'Oh, no! They are at least ten years old. I have not a garment that is not quite that....But I thought you might see something different about

me today because I became a widower at two-thirty this morning.'

He had been looking forward to the cremation of his wife, having enjoyed the process when his mother and sister were incinerated. 'But cremation is not what it was,' he reported [sadistically]. 'You can't see the body burned; it's a very unsatisfactory ceremony these days.'

After the ceremony he declared that 'I am now the most eligible man in England,' and next day that 'there is no need to prolong this state. The guns have been fired, and now it's time to strike up the music.'

A month later he said: 'Everybody tells me that I am looking well, and I can't very well say it's relief at my wife's death, but it is, you know.' He stated: 'If you had forty-odd years of love and devotion such as I have had, you would know what freedom meant, and I am enjoying this here for the first time.' (Pearson, 1950b, pp. 69–71.)

Women were not of primary importance in Shaw's life; they always appealed far more to his imagination than to his bodily needs. From boyhood onwards he dreamed of fair women, but there was a strain of feminine fastidiousness in him that frequently prevented him from realizing in the flesh what was ideal in the spirit. Even in the domain of sexual desire, there was an impersonality, an anonymity, about his requirements that showed his longing to lift the physical experience on to a more imaginative plane. He once said that the sexual act was to him monstrous and indecent and that he could not understand how any self-respecting man and woman could face each other in the daylight after spending the night together. What made the Garden of Eden legend incredible was His (God's) deliberate combination of the reproductive with the excretory organs and consequently of love with shame. (Pearson, 1950a, pp. 90–1).

Shaw doubted whether children should know who were their parents or the parents to be able to identify one another. The most satisfactory method, thought Shaw, would be for a crowd of healthy men and women to meet in the dark, to couple, and then to separate without having seen one another's faces. Love, in the sense of a close emotional and sexual relationship, played no part in Shaw's life. 'What people call love is impossible except

as a joke...' (Pearson, 1950 a, p. 90). These certainly are not the views of a man who has experienced an oedipal attachment to his mother.

When we turn from Shaw's life to his work, we find his writing replete with ideas founded on abhorrence of sex because of his hatred of women. In his preface to *St Joan* he writes: 'Her ideal biographer must...be capable of ...regarding woman...not as a different kind of animal with specific charms and specific imbecilities'. He continues: 'It is not necessary to wear trousers and smoke big cigars to live a man's life any more than it is necessary to wear petticoats to live a woman's' (Downer, 1961, p. 643). This last sentence makes us wonder about Shaw's confusion as to his sexual identification.

In *Man and Superman* Shaw presents a view of women as exploiters of men who unconscionably resort to every stratagem without regard to fairness in their unrelenting pursuit of marriage and motherhood. Men, on the other hand, have no real interest in marriage and are by nature 'artists' dedicated to the creation of beauty. In speaking of the artist, is he not referring to himself? Here his views on the 'mother women' are clothed in a philosophy of love, marriage, and sex that is expressed in high sounding verbiage which dazzles an audience and thus conceals its hateful nature:

TANNER: It is the self-sacrificing women that sacrifice others most recklessly. Because they are unselfish, they are kind in little things. Because they have a purpose which is not their own purpose, but that of the whole universe, a man is nothing to them but an instrument of that purpose.... [The Artist] gets into intimate relations with [women] to study them, to strip the mask of convention from them, to surprise their inner most secrets, knowing that they have the power to rouse his deepest creative energies....Of all human struggles there is none so treacherous and remorseless as the struggle between the artist man and the mother woman. It is a woman's business to get married as soon as possible, and a man's to keep unmarried as long as he can...[Petrarch

and Laura or Dante and Beatrice] never exposed their idolatry to the test of domestic familiarity.

DON JUAN: Marriage is the most licentious of human institutions...and a woman seeking a husband is the most unscrupulous of all the beasts of prey.

TANNER: Marriage is to me apostasy, profanation of the sacntuary of my soul, violation of my manhood, sale of my birthright, shameful surrender, ignominious capitulation, acceptance of defeat....To the women, I, who have always been an enigma and a possibility, shall be merely somebody's else's property—and damaged goods at that: a second-hand man at best.

(Downer, 1961, pp. 643–60 *passim*.)

In other words, when he gets married, the woman will find out that he is 'damaged goods', a 'second-hand man'. This seems to imply his inability to perform sexually. One wonders if Shaw here sees himself as the socialist and writer Tanner.

In *Candida*, Shaw delineates women as manipulators of men who delude their husbands into believing that they are the masters of the household while all the time it is their wives who manoeuvre them like puppets. Thus, when Candida is choosing the weaker of the two men, Marchbanks the poet and Morell her husband, she says:

Ask me what it costs to be James's mother and three sisters and wife and mother to his [Morrell's] children all in one....When there is money to give, he gives it; when there is money to refuse, I refuse it. I build a castle of comfort and indulgence and love for him, and stand sentinel always to keep little vulgar cares out. I make him master here, though he does not know it, and he could not tell you a moment ago how it came to be so.

(Shaw, 1948, p. 266.)

When, at the end of the play, it is clear that Candida has chosen her husband Morrell the weaker of the two, Marchbanks the poet is made to appear much relieved at having escaped the bondage and exploitation of marriage:

MARCHBANKS: Let me go now. The night outside grows impatient.

particular respect like her' (pp. 104, 520). It seems to us that Shaw identified not with Lee but with his mother, and, like her, loved Lee and overestimated him—his love object. His interest in music—he was a music critic for many years—can easily be explained as a facet of his identification with his music-mad mother.

Shaw's fixation at the pre-oedipal level produced much pain for the women around him and possibly for himself, but it may also account for his creativity in literature. Edith Jacobson (1950) has observed that there are creative persons (artists) in whom 'the analysis of their creative activity regularly shows intensely cathexed unconscious feminine reproductive phantasies....It appears that creative work quite normally is the main channel for sublimation of feminine reproductive wishes in men.' This is confirmed by Kris (1953), who contends that a certain degree of desexualization (and disaggressivization) seems to be a condition for success in creative activities; whether the ego will develop efficient productive activity depends to a large degree on the process of neutralization.

Would Shaw, if he had gone through an oedipal conflict and its solution, have been less creative? Would he have been less critical, less sarcastic, less blasphemic, less wise and witty? In any case, we are inclined to think that he would have given less pain to the women in his life and would have been a happier person himself. This writer of comedy who had a 'tragic cry in his soul' and resembled a 'great saint' of the Middle Ages, ranting against 'muddle-headedness' and preferring 'reason over unreason' was, through these very traits, writing out the emotional problems of his life.

REFERENCES

CLARK, B. H. & FREEDLEY, G. (1947). *A History of Modern Drama*. New York: Appleton-Century.

DENT, A. (1952). *George Bernard Shaw and Mrs Patrick Campbell: Their Correspondence*. New York: Knopf.

DOWNER, A. S. (1961). *The Theater of Bernard Shaw*. New York: Dodd Mead.

ERVINE, St J. (1956). *Bernard Shaw: His Life, Work, and Friends*. New York: Morrow.

FENICHEL, O. (1945). *The Psychoanalytic Theory of Neurosis*. New York: Norton.

GASSNER, J. (1960). *A Treasury of the Theater*. New York: Simon and Schuster.

HENDERSON, A. (1956). *George Bernard Shaw: Man of the Century*. New York: Appleton-Century-Crofts.

JACOBSON, E. (1950). Development of the wish for a child in boys. *Psychoanal. Study Child*, vol. 5. New York: International Universities Press.

KILTY, J. (1960). *Dear Liar, A Play Adapted from the Correspondence of Bernard Shaw and Mrs Patrick Campbell*. New York: Dodd Mead.

KRIS, E. (1953). Psychoanalysis and the study of creative imagination. *Bull. N.Y. Acad. Med.* (2nd Series). New York: Charles Morchand.

LAMPL DE GROOT, J. (1946). The pre-oedipal phase in the development of the male child. *Psychoanal. Study Child*, vol. 2. New York: International Universities Press.

MAGILL, F. N. & KOHLER, D. (1958). *Cyclopedia of World Authors*. New York: Salem Press.

PEARSON, H. (1950a). *G.B.S., A Full Length Portrait*. New York: Harper.

PEARSON, H. (1950b). *G.B.S., A Postscript*. New York: Harper.

SHAW, B. (1930). *Collected Works*. New York: Wise.

SHAW, B. (1948). *Nine Plays*. New York: Dodd Mead.

SHAW, B. (1949). *Sixteen Self Sketches*. New York: Dodd Mead.

VAN DER LEEUW, P. J. (1958). The pre-oedipal phase of the male. *Psychoanal. Study Child*, vol. 13. New York: International Universities Press.

WEISSMAN, P. (1958). Shaw's childhood and Pygmalion. *Psychoanal. Study Child*, vol. 13. New York: International Universities Press.

Reviews

Psychiatric Nursing. Pp. xi + 112. By MADDISON, DAY and LEABETTER. (40s.) E. and S. Livingstone Ltd.

Maddison, Day and Leabetter are a psychiatrist, nurse tutor and psychologist, respectively, working in New South Wales, Australia, where there has been a dynamic change in the psychiatric services of that State. Their co-operation on the nurse training programme has produced this excellent textbook which was designed to meet a real need in nursing.

The book is well written having a simple, easily read style. The psychological and psychiatric aspects of each illness are dealt with before the nursing care is discussed and the student therefore has a well-balanced picture of what the nursing care is supporting. The clever line drawings put many points over with emphasis in a humourous style.

The specialized chapters are valuable in presenting the student with a sound introduction to mental deficiency, child psychiatry and clinical psychology. The chapter on psychiatric social work is very well written and deserves a wider audience than student nurses.

A very welcome feature is the section on recommended reading and should prove to be a good guide to the stocking of a nurses' library, and the student's own bookshelf.

The authors are to be commended on producing one of the finest books on psychiatric nursing to emerge in recent years. The only factor which may put student nurses off buying, and nurse tutors from recommending the book is the price of 40s., but any student who wishes to practice psychiatric nursing competently must be prepared to buy a quality tool such as *Psychiatric Nursing*.

R. T. J. FARMER

Experiments in Motivation. Edited by H. J. EYSENCK. (Pp. 424. £5.) London. Pergamon Press. 1964.

Although this volume is edited by Eysenck, he demonstrates that he is still the most prolific writer in present-day psychology by contributing half of the twenty-four papers which constitute the book. Turning aside from his customary field of personality study, Professor Eysenck now takes up the important question of the effects of motivation and drive in human and animal behaviour. The book falls naturally into two main parts, the first dealing with experiments with human subjects, and the second on experiments with animals. As each paper examines the influence of drive level on different aspects of psychological performance, it is obvious that much depends on the initial criteria by which drive level is assessed. The subjects involved in the first section of the book were all apprentice students attending the Ford Motor Company's training school. Due to the high degree of competition for places in this school, candidates were required to pass through an initial screening procedure which included both written exams and a battery of aptitude tests. As these candidates are aware that only around 10 % of their number will be finally accepted for training, Professor Eysenck accepts that these youths will be highly motivated and it is these subjects who compose the 'high drive' group. The 'low drive' group are similarly selected from students who have already passed the selection procedures and have in fact been accepted for apprentice training. There are of course any number of obvious objections to this manner of establishing an initial dichotomy between high and low drive subjects. The two groups differ in a number of variables such as age, intelligence, their performance on tests measuring psychomotor co-ordination, dexterity and spatial ability. In his introductory chapter, Professor Eysenck comments on some of these objections, and argues that these objections, and his conclusion that the differences between the two groups are unlikely to affect radically his later findings, is by no means unreasonable. The initial criteria used to 'establish' drive level in the case of the animal subjects is even more dubious. Proceeding from the assumption that drive level in animals is related to emotionality, Eysenck utilizes the open-field test devised by Hall, to measure the emotional reactivity of rats. In essence this consists of placing the animals in a new standard environment under a

CANDIDA (to Marchbanks): Make a little poem out of the two sentences: ...when I am 30, she will be 45, when I am 60, she will be 75.

MARCHBANKS: In a hundred years, we shall be the same age. But I have a better secret than that in my heart.

Just before the curtain is to come down, Shaw has added the note: 'They [Candida and her husband Morrell] embrace. But they do not know the secret in the poet's heart.'

Much speculation has been made about the meaning of this 'secret'. In the light of Shaw's hostility toward women, one wonders whether the secret is not merely the good fortune that has befallen him now that he is a free man who can devote himself to the life of a poet unencumbered by love, marriage, or sexual relations. Does the poet Marchbanks stand for the author Shaw?

In middle age, Shaw wrote several disquisitory plays on marriage. The preface to *Getting Married*, one of these plays, contains these passages:

St Paul's instinctive recoil from [marriage's] worst aspect as a slavery to pleasure which induces two people to accept slavery to one another has remained an active force in the world to this day, and is now stirring more uneasily than ever. No healthy man or animal is occupied with love in any sense for more than a very small fraction indeed of the time he devotes to business and to recreations wholly unconnected with love. A wife entirely preoccupied with her affection for her husband, a mother entirely preoccupied with her affection for her children, may be all very well in a book (for people who like that kind of book); but in actual life she is a nuisance.

The revolt against marriage is by no means a revolt against its sordidness as a survival of sex slavery. It may even plausibly be maintained that this is precisely the part of it that works most smoothly in practice. The revolt is also against its sentimentality, its romance, its Amorism, even against its enervating happiness. Marriage is legalized impurity.

Note how Shaw displays his fear of taking masculine responsibility, his wish for passivity, to be taken care of:

Family life will never be decent, much less en-nobling until this central horror of the dependence of woman on man is done away with. At present it reduces the difference between marriage and prostitution to the difference between Trade Unions and unorganized casual labor.

The British home [is] the Holy of Holies in the temple of honorable motherhood, innocent childhood, manly virtue, and sweet wholesome national life. But, with a clever turn of the hand, this holy of holies can be exposed as an Augean stable, so filthy that it would seem more hopeful to burn it down than to attempt to sweep it out.

(Shaw, 1930, pp. 190–228 *passim.*)

It is noteworthy that Shaw's picture of women as expressed in his notions of love and marriage in this Preface shows that he views sex as filth, impurity, indecency, and sordidness. This attitude could be explained by his childhood anger at his ungiving, harsh, and cold mother. The hostility to women observable in his plays and in his adult life is, basically, the hostility to his mother in literary form and in real life, the anger of the anally fixated child.

Shaw was attached, he said, to many women without the least stirring of the sex urge, again pointing to his impotence. At the age of nearly 29 he wrote in his diary that he was still a 'virgo intacta' (Ervine, 1956, p. 152), then told of a 'seduction' by a voluptuous widow fifteen years his senior. 'I was an absolute novice', he stated, 'I did not take the initiative.' Subsequently he wrote to a friend a full account of his 'seduction'. This sharing of the sexual experience with a man smacks of homosexuality. He called himself 'a virgin' and 'a novice' and finally experienced the sex act as a 'seduction', putting himself into the feminine (homosexual) role completely. He believed that 'the sex act is often displeasing to the female, who suffers it because her passion for posterity cannot be gratified without it' (Ervine, p. 381). 'The man', he said, 'prefers words to progeny.' It would seem that he was unable to perform and to satisfy women and invented a philosophic excuse for his impotence.

'I hold chastity to be a passion', he wrote (Shaw, *Sketches*, 1949, p. 176). So he

married, at age 42, Charlotte Payne-Town-send, age 41, making a contract with her that they would have no sexual intercourse. The life that he led with her he called 'contractual sexlessness'. He stated at the time of his marriage: 'Romance in the sense of impassioned love and sexual gratification was unthinkable' (Henderson, 1956, p. 820). His 'affairs' with Mrs Campbell and the other women in his life were similarly without sexual contact, despite his high flown, romantic words of description and endearment. It is probable, therefore, that Shaw was impotent, a latent homosexual, and that his relish of teasing and hurting women was the expression of a pre-oedipal oral-sadistic and especially anal fixation.

In describing the mechanism of homosexuality, Fenichel (1945) states: 'Pregenital fixations, especially anal ones, and the readiness to substitute identification for object relation are necessary prerequisites. (Readiness is combined with self love.) The probability of homosexual orientation is increased the more a boy tends to identify with mother. Children in general tend to identify with the parent from whom they have experienced the more impressive frustration' (p. 337). When Shaw was 'still as tall as his father's boots', he said: 'Mamma, I think papa's drunk'. She turned away with impatience and disgust. 'When is he ever anything else?' (Pearson, 1950*a*, p. 51). Certainly the strong, ungiving, harsh mother, 'firm-minded and emphatic', lent herself more to identification than the 'easy-going, non-assertive father' who spent most of his time in a drunken stupor.

Shaw's relationships to women were not love affairs. He exploited them for his plays; he derived immense satisfaction from bragging about his 'conquests', that is, his stimulation of their desires without satisfying them. He was incapable of satisfying them. He was impotent and incapable of love. An anal fixation in men is responsible for the dirt conception of sexuality, certain men perceiving sexuality in anal terms only, 'as if it were a bathroom affair' (Fenichel, 1945, pp. 276, 289, 334). Certainly Shaw fits into this category.

Lampl de Groot (1946), who has dealt with the influence of the pre-oedipal relation between mother and male child, particularly from the point of view of the sexual life of the adult male, writes: 'The degraded sexual partner...is heiress to the image of the mother of the pre-oedipal phase. She has inherited the intense hostility that the little boy may have felt for her (early ambivalence).' Fenichel confirms the hostility of such a man: 'In quite a number of male homosexuals the decisive identification with the mother is an identification with the aggressor, that is, in most boys who are very much afraid of their mothers' (p. 337). Van der Leeuw (1958) adds: 'The boy (in the pre-oedipal phase) wants to possess everything, to be able to do everything, and to experience everything the mother possesses, can do, and experiences.... These feelings of rage, jealousy, and rivalry, but especially those of helplessness, which rouse a violent, destructive form of aggression against the mother, play an important part in many men. It may be a fixation point.'

From this point of view, additional light is shed on the relationship between Shaw and Vandeleur Lee, his mother's lover, with whom she went away to London, leaving her husband and son behind, but taking her daughters with her. Weissman (1958) maintains that Henry Higgins, in Shaw's *Pygmalion*, is unconsciously cast in the mould of Lee, who was a father figure for Shaw. Weissman considers 'Shaw's oedipal conflict centred not only in the usual drama of father, mother, and son, but additionally complicated by Lee and his mother's admiration for the latter'. Lee was a hero to Shaw and was supposedly his 'parental rival'. In Shaw's oedipal conflict with Lee, says Weissman, he identified himself with Lee.

As Fenichel points out, 'father images are not only castrators; they are also homosexual objects....The homosexual man identifies himself with his frustrating mother in one

bright light, and to measure their emotional reactivity in terms of 'the amount of defaecation as measured by the number of faecal boluses produced'. Rats with a high defaecation score were mated together, as were rats with a low defaecation score, eventually to produce two distinct strains, henceforth to be known as the Maudsley Reactive and Non-reactive strains. Animals selected from these two strains are used in a number of experiments on the effect of drive on animal behaviour —excretera, excretera.

Although each experiment reported in this book is carried out with the careful and rigorous methodology one associates with the Editor and his colleagues, it is very seldom that these experiments provide any definite conclusions. Indeed almost every chapter ends with the suggestion that the experiment requires to be repeated before any conclusions can be reached. One wonders if the inconclusive findings are not directly related to the highly debatable validity of the initial procedures by which drive level was measured. Apart from the reporting of specific experiments on high and low drive subjects, the book also contains a number of very useful reviews of previous literature on interactions between motivation and test performance. It is perhaps a reflexion on the main context of this volume that it is these reviews which contain the most interesting and useful information on the present state of motivation theory.

ANDREW MCGHIE

Readings in Psychology. Edited by JOHN COHEN. (Pp. 414. 52s. 6d.) London: George Allen and Unwin Ltd. 1964.

It is a difficult task for any reviewer to evaluate a volume in which the list of contributors read like a *Who's Who* of British psychology. The twenty-three contributors (no less than seventeen Chairs between them), have collaborated in choosing topics which highlight recent advances in psychological thinking. Many of the papers submitted have been seen in published form before, but most of the authors have made some attempt to bring them up-to-date. Although the twenty-three chapters cover a wide range of diverse topics, they are arranged in some degree of logical sequence. The first six chapters deal with historical and theoretical concepts. The central section of the book, comprising ten chapters, deals with experimental investigations of higher mental processes. The chapters forming the last section of the book are concerned with more specific topics, such as emotion, stress reaction, psychoanalytic research, industrial psychology and ethology. It is of course impossible to deal with each contribution in a short review, and any selection would reflect only the reviewer's own interests. Comparing the volume as a whole with similar psychological surveys published in the past, one is impressed by the implicit acceptance of the need for psychological theories to develop out of rigorous experimental studies. A number of the authors do, however, display a notable degree of ambivalence to the restrictions of some experimental disciplines. Professor Cohen expresses impatience with the limitations of learning theory and argues that it is time psychologists returned to explore 'the flora and fauna of their own minds'. Professor Drever, in introducing his chapter on perceptual organization, takes a somewhat similar view of the strict hypothetical-deductive method, likening the Hullians, Eysenckians and others to 'mammoths marching across the icy wastes', indulging in meaningless scientistic rituals. Although most of the other contributors clearly align themselves with the objective experimental approach, their writings too indicate the present tendency to apply these methods in studying not only the stimulus variables, but the organism itself. As Professor Drever comments, 'we must take into account the programme as well as the data being processed'. It is also striking that, although information theory forms in itself the subject of one chapter, its influence is very much in evidence in most of the contributions dealing with attention, perception, learning, memory and thinking.

As a source of specific information, this type of book is at times frustrating, in that most of the work reviewed is by necessity greatly condensed. As a representation of the scope of modern psychological studies and theories derived from these studies, this volume, however, admirably succeeds in its purpose and can be warmly recommended.

ANDREW MCGHIE

Handbook of Mental Deficiency. Edited by
Norman R. Ellis. (Pp. 722.) McGraw-
Hill Series in Psychology. 1963.

The first thing to be said about this book is that
it is not a Handbook of Mental Deficiency. It
does not only omit all mention of the medical
aspects of mental deficiency, but also it does not
discuss matters of importance to clinical psycho-
logy. Indeed the only matter concerned with
aetiological considerations of conditions causing
mental defect are a page and a half on chromo-
somes and four kayotypes of a family with
mongolism and a rare form of translocation. It
would have been better had the book been called
'Psychological Theory and Research Relating to
Mental Deficiency' for it is concerned with psy-
chological theories in so far as they have a bearing
on psychological research in mental deficiency.

Except for Professor Luria and Miss Mary
Woodward all the authors are American and the
majority of them are or have been connected with
the George Peabody College. This and the fact
that most of the contributors are young men gives
the book verve and cohesion, although this in
places is responsible for a concentration on
American work and relative neglect of publications
elsewhere.

The explicit aim of the book is to assess the
status of behavioural research and theory on
mental deficiency, and the chapters have been
grouped into two parts. Part I is devoted largely
to an examination of the general psychological
theories which have been adduced to throw light
on the problems presented by mental defect. The
theories so examined in six out of ten chapters of
Part I are 'The Field Theory', 'The Social
Learning Approach', 'The Hull–Spence Be-
haviour Theory', 'The Stimulus Trace Concept
in Relation to Behavioural Inadequacy', 'Piaget's
Work on Intellectual Development' and 'Social
Psychological Theories in Relation to Mental
Deficiency'.

The remaining four chapters of Part I depart
from this scheme of presentation and deal with
selected formulations of psychological theories
being brought to bear on specific problems in the
field of mental defect. They are 'The Role of
Attention in Retardate Discriminate Learning'
(using a mathematical approach), 'Intelligence
and Brain Damage', 'Genetic Aspects of Intelli-
gent Behaviour', and an account of experimental

studies on the subject carried out in the Soviet
Union.

Part II continues to discuss specific problems
giving full summaries of the relevant research
work and its theoretical implications: the eleven
chapters here are devoted to: 'Learning Con-
sidered as Verbal, Perceptual-motor and
Classical Conditioning', 'Discrimination Learn-
ing', 'Problem Solving and Conceptual Behavi-
our', 'Sensory Processes', 'Preceptual Processes',
'Language and Communication', 'Psychophysio-
logical Studies', 'Abnormal Behaviour', 'Motor
Skills' and 'Research in Activity Level and
Academic Skills'.

The book follows the tendency general among
psychologists, studying the problems of mental
defect, to deal with all defectives as if they were a
homogeneous group. This is in marked contrast
to the medical trend towards analytical study of
differences and their correlation with aetiological
factors. This difference of approach is particularly
evident in the discussion on brain damage. In
some cases this attitude is justifiable, for example
social adjustment is more likely to be a function
of I.Q. than of a nosological entity responsible for
the lowered intelligence. One wishes, however, that
more attention had been paid to the differences
found among the various types of patient.

The book, for all its length, and it has over 700
pages, narrows its approach largely to problems
of experimental psychology. Relatively little
space is devoted to problems of personality
structure, social behaviour, emotional and
dynamic factors.

One is tempted to compare this book with
Sarason's which appeared some 15 years ago and
has been a classic on the psychological aspects of
mental deficiency. The striking difference is the
relative unimportance accorded to the clinical
aspects and the complete absence of references to
problems of intelligence and its measurement. The
encouraging aspect which emerges from the com-
parison is the volume of research which is being
reported. It is quite obvious that the problems
presented by mental deficiency have not only
attracted a much greater amount of research than
was the case 15 years ago, but that the problems
have been attacked from the points of view of
many more disciplines.

To summarize: the book is a handbook of
psychological research in mental deficiency (with
a definite bias towards experimental research). It

is a most valuable addition to the bookshelves not only of research psychologists, but every library of an active Mental Deficiency Hospital.

A. SHAPIRO

The Psychoanalytic Study of the Child. Vol. XVII by RUTH S. EISSLER *et al.* ($8.50.) New York: International Universities Press Inc. 1962.

The present annual maintains the fine standard of its predecessors, and in all four sections, Theoretical, Developmental, Clinical, and Applied there are interesting contributions.

The paper by Miss Freud 'Assessment of Childhood Disturbances' has already aroused considerable discussion and controversy, and is in a sense a landmark. Besides presenting a detailed outline for a diagnostic profile, by implication it confronts the clinician with a responsibility to the community to give an assessment, to attempt a prognosis—in short, to be committed.

A series of original articles on various aspects of the super ego constitutes virtually a short symposium on the subject. There is a poignancy about the unfinished essay by the late Ernst Kris which should not be allowed to obscure its excellence, both as a sensitive clinical record and as a penetrating discussion of theory.

While the observations of Rene Spitz on the auto-erotic activity of deprived infants are as fascinating as they are unexpected, the conclusions he draws (with the assistance of Harlow's monkeys) on object-relations and masturbation were not altogether convincing. It is, however, a long time since this reviewer encountered a paper which suggested so many possible starting points for observational research in early childhood.

It is not the first time that the widespread practice of childhood tonsillectomy has been challenged but seldom have the facts been marshalled with such logic and lucidity as by Dr Lipton. It seems to me a great pity that the review section of this article was relegated to an Appendix in small print. I hope the author will seek the editor's permission to re-publish this in a general medical journal where it should have a considerable impact.

There is much more I have not mentioned, but there is no need. This volume like others in the series, is essential reading for those who wish to keep abreast of current developments not only in psychoanalysis but in child psychology and psychiatry.

F. H. STONE

The Annual Survey of Psychoanalysis. Vol. VII. 1956. Edited by JOSEPH FROSCH, M.D., and NATHANIEL ROSS, M.D. (Pp. 517. $12.00.) New York: International Universities Press Inc. 1963.

The seventh volume of the annual survey deals with 1956, Freud's centenary year. A survey, in 485 pages of text, appearing 7 years after the year in question has at first sight a reflective, even a dusty quality. This is illustrated by the fact that it has not been considered necessary to place the figures 1956 on the jacket or for the editors to give any note of explanation of the principles on which this 'comprehensive survey' is compiled.

None the less, to read abstracts of remembered and unknown papers of international origin at this distance of time becomes addictive. It is a mark of quality that nearly all the abstracts are completely comprehensible. The surveys of trends are perhaps less satisfactory. A year is not usually a long enough period for such an assessment, though some papers (such as Geza Roheim's concerning the relationship of child-rearing habits to the development of culture) can be used to point up areas of neglect.

Freud's centenary year is of particular interest. This volume enables us to review our review of 1956 after the heat of the moment has died. In the hundred years since Freud's birth the intellectual climate of the world has been changed chiefly by Marx, secondly by Einstein and, in a part of the Western World by Freud, the greatest of the three. This being so, one might expect that the life of perhaps the greatest genius Man has produced should be assessed in terms of the historico-social conditions which enabled his genius to flower in the way it did. In this one is disappointed. Though several contributors mention the intellectual sources of Freud's work there is no attempt to relate the growth of psychoanalysis, to the *Kulturkampf*, for instance, itself based on the need for secular mass-education of an expanding technological economy or to its necessary accompaniment, the emancipation of women.

Freud opened the way to a new understanding of Man; a certain lack of sophistication in the historical reflexions on his centenary leaves the impression that we are far from having succeeded in thinking through the implications of this crucial intellectual revolution for our social organization.

<div align="right">JOHN KLAUBER</div>

The Self and the Object World. By EDITH JACOBSON. ($5.00.) New York: International Universities Press Inc.

This important work shows the increasing attention which is now being paid to the problem of Identity, the author reminding us at once that, while Hartmann (1950) has suggested precise definitions of 'Ego', 'Self', and 'Self-representations', there is no generally accepted psychoanalytical definition of Identity. Referring to her earlier papers on the subject she comments that now the scope of psychoanalysis is widening to deal with borderline and psychotic cases presenting psychotic regressions and deterioration of object relations and super ego and ego functions, with dissolution of those essential identifications on which the experience of personal identity is founded. A review of the literature on Identity is followed by discussion of the infantile period of the super-ego formation and the complex developmental processes during the adolescent period, which are so significant for identity formation and the ultimate regulation of self-esteem. Dr Jacobson explains that she must stick to the aspects of the problem most essential to the hypotheses put forth, disregarding many studies which are nevertheless pertinent to the subject discussed. This is one of the inevitable problems in dealing with a complex subject of this nature and though some may find the book in places difficult to read they need not be put off, as the main themes unfold with increasing clarity.

A review of the psychoanalytical concepts of primary and secondary narcissism and masochism, with attempts to elucidate some of Freud's more puzzling remarks deserves high praise. Dr Jacobson postulates a stage of 'undifferentiated' energy in place of Freud's theory of 'desexualized' energy at one point and from this shows a re-adjustment of thinking on the subject of the death instinct and primary narcissism. Dilemmas are faced and terminological confusions are clarified so that Ego, Self and Self-representations acquire more meaning. Her reasoning is persuasive and her attempt to give a precise metapsychological description of the original psychoeconomic condition in the infant is most competent. An early chapter deals with the fusions between Self and object images and the earliest types of identifications, the subtle interplay between mother and infant and the harmful effects of separation. Too big an issue seems to develop over criticism of Bowlby's views on feeding and weaning experiences because there is strong agreement with him on the significance of early separation anxiety, and also via a quotation of Lichtenstein's statement that in the earliest symbiotic situation the mother *imprints* on the child an 'identity theme'.

Discussing the mechanisms of introjection and projection, on which all forms of identification are founded, Dr Jacobson makes special reference to Melanie Klein's ideas on object image and super-ego formation. She feels that theoretical precision suffers generally from our failure to make clear distinctions between external objects and their endopsychic representations, and that Melanie Klein compounded this confusion by failing to distinguish the latter from what she called 'internalized' or 'introjected' objects, also equating 'introjects' with the infantile super ego. She finds Klein's terminology confusing, and returns to criticize her theoretical conclusions again later. Meantime there are excellent chapters on the child entering his second year and discovering his identity, and advancing to object-relations and selective identifications, then the child's discovery of his sexual identity and the building up of his Ego.

Part II of the book begins with the forestages of super-ego development and a further criticism of Klein's theoretical differences. This does not seem to be of great importance to anyone versed in the development of Klein's concepts, especially when Dr Jacobson goes on to give a graphic and convincing account of pre-oedipal conflict and ego development which will appeal to many Kleinian readers. Possibly it emphasizes certain slants on the dynamics of the child's growing awareness of the Self as an entity, i.e. of his identity, which have not been stressed by Klein and her followers, but one derives hope from a work of this quality for the much needed integration of the varying theories. Dr Jacobson does a

lot to clarify confusion of terms and it must be remembered that the early developmental stages being charted are in their very nature confused. And whatever terminological or theoretical differences arise, Klein and her followers such as Rosenfeld have made a point of contacting and tolerating the confusions in the depths, and gaining stronger footholds and a sense of relief through a surer sense of Identity, in a way which suggests validity of concept.

Dr Jacobson describes well the child's narcissistic expansion and advancing ego development, his ability to tolerate frustration and deprivation and even severe aggression and profound narcissistic hurt and constriction by the mother better than her weakness and loss, his increasing need for a *good* mother or father, *good* in the sense of consistently strong. She describes oral, anal and genital forms of aggressive devaluation, and the child experiencing his degraded love objects either as weak or empty, or as dirty and disgusting, or as destroyed and castrated—a disheartening experience of disillusionment. Other chapters deal with Idealization of the Love Objects, Ego-ideal formation, consolidation of Super-ego components, Latency, guilt, shame and inferiority, and the special events in adolescence and in adult life relating to development of identity. The author draws attention to Anna Freud's comparison of the adolescent's resistances to psychoanalytic treatment with the difficulties encountered in patients during periods of mourning or during unhappy love affairs. There are references to the swings of mood in adolescence, the saddening farewell to childhood and the self and objects of the past. Erikson is quoted as saying in 1956 '*Identity formation*...begins where the usefulness of identification ends'. One begins to feel towards the end that some of these crucial phases in the development of Identity lack something of the poignancy of the same story when told in Kleinian language, may be because of the particular dynamic impact involved in the discovery of new identity and appreciation of the object world through the attainment of the depressive position as described by Klein.

This fine exposition with its main theme the process of Identity formation is an important contribution to psychoanalytical knowledge.

SIMON LINDSAY

THE
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OF
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BEING THE MEDICAL SECTION OF THE
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